CIVIL COMMITMENT AND TREATMENT OF NARCOTIC ADDICTS

HEARINGS

BEFORE

SUBCOMMITTEE NO. 2

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

EIGHTY-NINTH CONGRESS

FIRST AND SECOND SESSIONS

ON

H.R. 9051, H.R. 9159, H.R. 9167, H.R. 9249, H.R. 9886, H.R. 10762, H.R. 11409

TO PROVIDE FOR CIVIL COMMITMENT, TREATMENT, AND REHABILITATION OF NARCOTIC ADDICTS AND THE ADJUSTMENT OF SENTENCING PROCEDURES FOR NARCOTIC OFFENSES

AND

H.R. 2979, H.R. 8880, H.R. 8884, H.R. 8888, H.R. 8892, H.R. 8896, H.R. 8900, H.R. 8904, H.R. 8908, H.R. 8912, H.R. 9002, H.R. 12050

TO AUTHORIZE CIVIL COMMITMENT IN LIEU OF CRIMINAL PUNISHMENT IN CERTAIN CASES INVOLVING NARCOTIC ADDICTS

JULY 14 AND 15; AUGUST 5, 6, AND 12, 1965, AND JANUARY 11 AND 19, 1966

Serial No. 10

Printed for the use of the Committee on the Judiciary

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BILLS PROVIDING FOR CIVIL COMMITMENT AND TREATMENT OF NARCOTIC ADDICTS

WEDNESDAY, JULY 14, 1965

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE NO. 2 OF THE
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 o'clock in room 4121 Rayburn House Office Building, Hon. Robert T. Ashmore (chairman of the subcommittee) presiding.

Mr. ASHMORE. The subcommittee will come to order.

This morning we are to take up important legislation regarding amendments to the narcotics law. We have a number of bills for consideration.

The first witness we shall hear will be the distinguished chairman of the House Judiciary Committee, who has introduced H.R. 9051, the purpose of which is to amend title 18 of the United States Code with respect to criminal procedures and sentencing, and for other purposes. We have a number of important witnesses. Mr. Celler will be first. We shall also hear the Attorney General of the United States and representatives of the Treasury Department and the Department of Health, Education, and Welfare, and others as we go along. I do not know just how many days will be consumed in these hearings, but we shall get started now and proceed as best we can.

(The bills follow:)

[H.R. 9051, 89th Cong., 1st sess.]

A BILL To amend title 18 of the United States Code with respect to criminal procedures and sentencing, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

CIVIL COMMITMENT

SECTION 1. (a) Part II of Title 18 of the United States Code is hereby amended by adding at the end thereof the following new chapter:

"CHAPTER 239—CIVIL COMMITMENT

"Sec.
"3811. Election of civil commitment.
"3812. Disposition of election claim.
"3813. Period of civil commitment.
"3814. Termination of civil commitment.
"3815. Credit for commitment period.
"3816. Limitations on use of determinations made under civil commitment procedure.
"3817. Contracting with States for facilities.
"3818. Operative date.
"3819. Definitions.

"§ 3811. Election of civil commitment

"(a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prose-

cution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this chapter.

"(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail or released on his own recognizance during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

"(c) The provisions of this Act shall not be applicable in the case of any person charged with knowingly selling narcotics to another for purposes of resale.

"§ 3812. Disposition of election claim

"(a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 3811, the Surgeon General shall cause such person to he examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this chapter as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

"(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

"(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution of facility to any other such institution or facility.

"(d) Whenever a drug user has been civilly committed pursuant to this chapter, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this chapter.

"§ 3813. Period of civil commitment

"(a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3812 of this chapter shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall he released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

"(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his in corrigibility or nonresponsiveness to medical treatment;

"(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

"(3) the expiration of thirty-six months following the date on which such person is so committed.

"(h) With respect to any person returned to the court pursuant to the provisions of paragraphs (2) or (3) of subsection (a), the court in order to insure that such person does not return to the use of narcotic drugs following his re-

lease from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

"(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

"§ 3814. Termination of civil commitment

"(a) If, while under any aftercare treatment program pursuant to section 3813, any person—

"(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

"(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States Marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

"(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 3813 of this chapter has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

"§ 3815. Credit for commitment period

"In any case in which the prosecution of criminal charges against any person under this chapter is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States Marshal and the Surgeon General pursuant to this chapter.

"§ 3816. Limitations on use of determinations made under civil commitment procedure

"Any determination by a court under this chapter that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this chapter, may be used in a further proceeding under this chapter, but may not be used against such person in connection with any criminal charge held in abeyance under this chapter, or in any other criminal proceeding.

"§ 3817. Contracting with States for facilities

"The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

"§ 3818. Operative date

"The provisions of this Chapter shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

"§ 3819. Definitions

"As used in this chapter—

"(1) the term 'narcotic drug' or 'narcotics' shall include the substances defined as 'narcotic drugs', 'isonipecaine', and 'opiate' in section 4731 of the Internal Revenue Code of 1954, as amended;

"(2) the term 'narcotic addict' means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such

habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction;

"(3) the term 'State' shall include the District of Columbia."

(b) The part analysis preceding chapter 1 of title 18, United States Code, is amended by adding immediately after chapter 237 the following item:

"239. Civil commitment ..... 3811."

SENTENCING PROVISIONS

SEC. 2. (a) Chapter 402 of title 18 of the United States Code is amended by adding at the end thereof the following new section:

"§ 5027. Applicability of certain narcotic violators

"Subject to the provisions of subsection (d) of section 7237 of the Internal Revenue Code of 1954, as amended, the provisions of this chapter shall be applicable to all persons otherwise eligible, who are convicted of violations of any Federal penal law relating to narcotics notwithstanding the fact that a mandatory penalty is prescribed for any such violation."

(b) The analysis of chapter 402 of title 18, United States Code, is amended by adding at the end thereof the following:

"5027. Applicability to certain narcotic violators."

SEC. 3. Section 4209 of title 18, United States Code, is amended by adding at the end thereof the following new sentence: "Subject to the provisions of subsection (d) of section 7237 of the Internal Revenue Code of 1954, as amended, the provisions of this section shall be applicable to all persons otherwise eligible, who are convicted of violations of any Federal penal law relating to narcotics notwithstanding the fact that a mandatory penalty is prescribed for any such violations."

SEC. 4. Section 2(h) of the Narcotic Drugs Import and Export Act, as amended (21 U.S.C. 176a), is amended (1) by striking out "not less than five or" and inserting in lieu thereof "for not"; (2) by striking out "less than ten or"; and (3) by striking out "For provision relating to sentencing, probation, etc., see section 7237(d) of the Internal Revenue Code of 1954.".

SEC. 5. (a) Subsection (a) of section 7237 of the Internal Revenue Code of 1954, as amended, is amended (1) by striking out "not less than 2 or" and inserting in lieu thereof "for not"; (2) by striking out "not less than 5 or" and by inserting in lieu thereof "for not"; and (3) by striking out "not less than 10 or" and inserting in lieu thereof "for not".

(b) Subsection (b) of section 7237 of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(b) SALE OR OTHER TRANSFER WITHOUT WRITTEN ORDER.—

"(1) Whoever commits an offense, or conspires to commit an offense, described in section 4705(a) or section 4742(a) shall be imprisoned for not more than 20 years and, in addition, may be fined not more than $20,000. For a second or subsequent offense, the offender shall be imprisoned for not more than 40 years and, in addition, may be fined not more than $20,000.

"(2) If any offender under paragraph (1) attained the age of 18 before the offense and—

"(A) the offense consisted of the sale, barter, exchange, giving away, or transfer of any narcotic drug to a person who had not attained the age of 18 at the time of such offense, or

"(B) the offense consisted of a conspiracy to commit an offense described in paragraph (A),

the offender shall be imprisoned not less than 5 or more than 40 years and, in addition, may be fined not more than $20,000."

SEC. 6. (a) Subsection (d) of section 7237 of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(d) NO SUSPENSION OF SENTENCE; NO PROBATION.—Upon conviction of any offense the penalty for which is provided in subsection (b)(2) of this section or in subsection (c) or (i) of section 2 of the Narcotic Drugs Import and Export Act, as amended, the imposition or execution of sentence shall not be suspended and probation shall not be granted. Any person convicted of any such offense (including convictions in the District of Columbia) and sentenced to a definite m of years other than life shall be eligible for parole in accordance with the visions of section 4202 of title 18 of the United States Code after such person

has served for a period of not less than the mandatory minimum penalty described by any such subsection for such offense. Any such person so convicted and sentenced to a term of life shall be eligible for parole in accordance with such section 4202 after such person has served for a period of at least 15 years of such life sentence."

TREATMENT OF FEDERAL PRISONERS

SEC. 7. (a) Chapter 301 of title 18 of the United States Code is amended by inserting immediately after section 4002, the following new section:

"§ 4002A. Use of State facilities for narcotic addicts

"(a) For the purpose of providing for the confinement, care, treatment, and rehabilitation (including vocational rehabilitation) of persons held under the authority of any enactment of Congress who are narcotic addicts, or who are suffering from a mental or physical condition which might be helped by proper care, treatment, or rehabilitation (including vocational rehabilitation), the Director of the Bureau of Prisons is hereby given authority, in addition to other authority available to him, to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States and subdivisions, specially equipped to provide such care, treatment, or rehabilitation, will be made available, on a reimbursable basis, for the aforementioned purposes.

"(b) As used in this section, and sections 4082A and 4082B of chapter 305 of this title, the term 'narcotic addict' means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction. As used in this subsection, the term 'narcotic drugs' shall include the substances defined as 'narcotic drugs', 'isonipecaine', and 'opiate' in section 4731 of the Internal Revenue Code of 1954, as amended."

(b) The analysis of chapter 301 of title 18, United States Code, is amended by inserting immediately after

"4002. Federal prisoners in State institutions; employment."

the following:

"4002A. Use of State facilities for narcotic addicts."

SEC. 8. (a) Chapter 305 of title 18 of the United States Code is amended by inserting immediately after section 4082, the following new sections:

"§ 4082A. Treatment authorized for certain persons committed to the custody of the Attorney General

"(a) If the Attorney General determines that any person committed to his custody pursuant to section 4082 of this chapter is a narcotic addict, or is suffering from a mental or physical condition, and might be helped by proper care, treatment, or rehabilitation (including vocational rehabilitation), the Attorney General is hereby authorized, in addition to other authority available to him, to designate as the place of confinement for such person, any appropriate institution or other facility of the United States, or any appropriate institution or other facility made available pursuant to section 4002A of this title, which is specially equipped to provide such care, treatment, or rehabilitation. The Attorney General may order any such person transferred from any one such institution or facility to any other such institution or facility.

"(b) Whenever the Attorney General determines that any person confined in an institution or facility pursuant to a designation by the Attorney General under subsection (a) of this section, or pursuant to an order of a United States court under section 4082B of this chapter, is no longer in need of such care, treatment, or rehabilitation, or that his continued confinement therein is no longer necessary or desirable, the Attorney General may transfer such person to any penal or correctional institution designated by the Attorney General to complete his original sentence. The time spent by such person in confinement in such institution or facility shall be considered as part of the term of his imprisonment.

"§ 4082B. Treatment authorized by the court for certain persons committed to the custody of the Attorney General

"In any case in which the court believes that a person convicted therein of violating a Federal penal law is a narcotic addict, or is suffering from a mental

or physical condition, and might be helped by proper care, treatment, and rehabilitation (including vocational rehabilitation), the court may, after pronouncing sentence against such person, order the Attorney General to confine such person in an appropriate institution or facility in accordance with the provisions of section 4082A of this chapter."

(b) The analysis of chapter 305 of title 18, United States Code, is amended by inserting immediately after

"4082. Commitment to Attorney General; transfer."

the following:

"4082A. Treatment authorized for certain persons committed to the custody of the Attorney General.
"4082B. Treatment authorized by the court for certain persons committed to the custody of the Attorney General."

SEC. 9. (a) Chapter 311 of title 18 of the United States Code is amended by inserting immediately after section 4203, the following new section:

"§ 4203A. Use of certain public and private agencies for purposes of supervising certain parolees

"(a) In any case in which a person confined in any institution or other facility in accordance with the provisions of section 4082A or 4082B of this title is thereafter authorized by the Board of Parole to be released on parole under section 4203 of this chapter, the Board may, in its discretion, impose as a condition to such release a requirement that the person be placed, during the period of his parole, under the supervision of an appropriate State, public, or private agency, organization, or group, which, in the opinion of the Board, is (1) qualified to supervise such person during the period of his parole; and (2) specially equipped to provide such care, treatment, rehabilitation, or aftercare as he might require during such period. The Board shall receive and consider any recommendation of the Attorney General which in his opinion would be helpful to the Board with respect to the parole disposition of any case pursuant to this section.

"(b) For the purposes of subsection (a) of this section, the Board of Parole is authorized to utilize the services and facilities of any State, agency, organization, or group referred to in subsection (a) in accordance with a written agreement entered into between such State, agency, organization, or group and the Board of Parole. Payment for such services and facilities shall be made in such amount as may be provided in such agreement."

(b) The analysis of chapter 311 of title 18, United States Code, is amended by inserting immediately after

"4203. Application and release; terms and conditions."

the following:

"4023A. Use of certain public and private agencies for purposes of supervising certain parolees."

FACILITIES

SEC. 10 (a) For the purpose of financially assisting the several States in the construction of facilities for the treatment and rehabilitation of drug abusers, there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the two succeeding fiscal years, the sum of $15,000,000.

(b) Sums appropriated pursuant to subsection (a) shall be available for use by the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary") in (1) making grants under this Act to assist financially any State (which has submitted and had approved a State plan as hereinafter provided in this Act) in the construction of facilities for the treatment and rehabilitation of drug abusers; and (2) furnishing technical assistance to such State in designing, locating, and constructing such facilities.

(c) Sums appropriated pursuant to subsection (a) of this section shall remain available until expended for payments with respect to projects on which applications have been filed under section 13 of this Act before July 1, 1968, and approved by the Secretary before July 1, 1969. The full amount (as determined by the Secretary) of any grant for a project under this Act shall be reserved from any appropriations available therefor; and payments on account of such grant may be made only from the amount so reserved.

SEC. 11. (a) Within six months after the enactment of this Act, the Secretary shall issue such regulations, applicable uniformly to all the States, as he may

determine necessary to enable him to carry out the provisions of this Act. Such regulations shall include, among others, provisions prescribing—

(1) general standards of construction for any such facility the construction of which is financed at least in part from a grant under this Act; and

(2) the kinds of facilities and services needed to provide adequate treatment and rehabilitation for drug abusers.

(b) The regulations referred to in subsection (a) may include provisions requiring that (1) before approval of any application for a project pursuant to a State plan is recommended by any Agency, an assurance shall be received, by the State filing such plan, from the applicant that a reasonable volume of treatment and rehabilitation services for drug abusers shall be made available to such drug abusers who are unable to pay for such services.

SEC. 12. (a) After the regulations referred to in section 11 have been issued, any State desiring to secure financial assistance under section 10 of this Act shall submit a State plan for carrying out the purposes of such section. Such plan must—

(1) set forth a program for construction of facilities for the treatment and rehabilitation of drug abusers which conforms with the regulations prescribed under section 11;

(2) designate a single State agency (referred to in this Act as the "Agency") as the sole agency for supervising the administration of the plan;

(3) contain satisfactory evidence that the Agency will have authority sufficient to carry out such plan in conformity with this Act;

(4) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(5) provide that the Agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

(6) provide for affording to every applicant for a grant for a project pursuant to a State plan an opportunity for hearing before the Agency;

(7) provide that the State will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) Any State desiring to submit a State plan as provided under subsection (a) shall submit such plan as a separate and distinct part of its State mental health plan submitted to the Public Health Service by the State's mental health authority in accordance with title III of the Public Health Service Act.

(c) The Secretary may approve any State plan (and any modification thereof) which is in substantial conformity with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

SEC. 13. (a) Any State or political subdivision thereof desiring to secure financial assistance under this Act for any project for the construction of facilities for the treatment and rehabilitation of drug abusers pursuant to an approved State plan shall submit, through the Agency, an application for a grant under this Act to assist it in carrying out such project. If any State and one or more political subdivisions thereof jointly participate in any such project, the application may be filed by one or more of the participants. The application shall set forth—

(1) a description of the site for such project;

(2) plans and specifications for such project in accordance with the regulations prescribed by the Secretary under subsection (a) of section 11 of this Act;

(3) reasonable assurances that title to such site is or will be vested in one or more of the applicants filing the application;

(4) reasonable assurances that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed;

(5) reasonable assurances that the applicant will meet the requirements, if any, for furnishing treatment and rehabilitation services to drug abusers who are unable to pay for such services;

(6) such other information and assurances as the Secretary may, by regulation, require; and

(7) reasonable assurances that all laborers and mechanics employed by contractors or subcontractors in the performance of work on construction of the project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a–276a–5); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

(b) The Secretary may approve any application filed under this section if he finds that the application (1) is in substantial conformity with subsection (a) of this section and all applicable regulations issued pursuant to this Act; (2) is in substantial conformity with the State plan approved under section 12 of this Act; and (3) has been approved and recommended by the Agency. No application filed pursuant to this section shall be disapproved by the Secretary until he has afforded the applicant an opportunity for a hearing. Any amendment of an application approved under this Act shall be subject to approval in the same manner as the original application.

SEC. 14. The payment of any grant to a State or political subdivision under this Act may follow the approval by the Secretary of the application of such State or subdivision. Any grant made pursuant to this Act for the construction of a project in any fiscal year shall include such amounts as the Secretary determines to be necessary in succeeding fiscal years for completion of the Federal participation in the project as approved by him. Payment of a grant may be made in advance or by way of reimbursement, and in such installments as may be determined by the Secretary, and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of this Act. Amounts paid under this Act with respect to any project for the construction of a facility shall not exceed two-thirds of the construction costs of such facility as determined by the Secretary.

SEC. 15. Whenever the Secretary, after reasonable notice and opportunity for hearing to the Agency, finds—

(1) that the Agency is not complying substantially with the provisions required by subsection (a) of section 12 to be included in its State plan, or with regulations under this Act;

(2) that any assurance required to be given in an application filed under subsection (a) of section 13 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 13;

the Secretary may forthwith notify such Agency that no further payments will be made under this Act for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph 1, 2, or 3 of this subsection; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments in connection with such State plan may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurances or plans and specifications, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

SEC. 16. If any facility with respect to which funds have been paid under this Act shall, at any time within twenty years after completion of its construction—

(1) be sold or transferred to any nonpublic organization; or

(2) cease to be used for the purposes for which it was constructed, unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant from the obligation to continue such facility for the purpose of providing treatment for drug abusers;

the United States shall be entitled to recover from the recipient of such funds an amount bearing the same ratio to the then value (as determined by agreement of the parties or by action brought in the United States district court for the district in which the facility is situated) of the facility, as the amount of the Federal participation bore to the cost of construction of the facility.

SEC. 17. If any recipient of a grant under this Act is dissatisfied with any action taken by the Secretary under section 12(c), 15 or 16 of this Act, such recipient may appeal to the United States court of appeals for the circuit in

which such recipient is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

SEC. 18. (a) The Secretary is authorized to appoint such technical or other advisory committees as he deems necessary to advise him in connection with carrying out the provisions of this Act.

(b) Members of any such committees not otherwise in the employ of the United States, while attending meetings of their committee, shall be entitled to receive compensation at a rate to be fixed by the Secretary, but not exceeding $75 per diem, including travel time; and while away from their homes or regular places of business, they be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons in the government service employed intermittently.

PROGRAMS OF CARE, TREATMENT, AND REHABILITATION

SEC. 19. (a) For the purpose of financially assisting the several States in establishing, developing, and maintaining treatment and rehabilitation services for drug abusers, there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the two succeeding fiscal years, the sum of $7,500,000.

(b) Of the amount appropriated pursuant to subsection (a) for each such fiscal year (1) not less than 80 per centum thereof shall be available for use by the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary") in (A) making grants under this Act to assist any State (which has submitted and had approved a State plan as hereinafter provided), in defraying expenses and other costs incurred by it in establishing, developing, and maintaining treatment and rehabilitation services for drug abusers (including the training of personnel necessary to operate such services and the conducting of statistical and biometric programs necessary for carrying out epidemiologic and longitudinal studies of drug addiction and abuse); and (B) providing technical assistance to such State in carrying out such services; and (2) not more than 20 per centum thereof shall be available for use by the Secretary in (A) making grants under this Act to assist any nonprofit organization (which has submitted and had approved an application as hereinafter provided) in defraying expenses and other costs incurred by it in establishing, developing, and maintaining such treatment and rehabilitation services as are referred to in clause (1) of this subsection; and (B) providing technical assistance to such organization in carrying out such services.

(c) Any sums appropriated pursuant to subsection (a) of this section shall remain available until expended for payments with respect to projects on which applications have been filed under section 22 or 23 of this Act before July 1, 1968, and approved by the Secretary before July 1, 1969. The full amount (as determined by the Secretary) of any grant under this section shall be reserved from any appropriations available therefore; and payments on account of such grant may be made only from the amount so reserved.

SEC. 20. (a) Within six months after the enactment of this Act, the Secretary shall issue such regulations, applicable uniformly to all the States, as he may determine necessary to enable him to carry out the provisions of sections 19 to 28. Such regulations shall include, among others, provisions prescribing

the kinds of treatment and rehabilitation services for drng abnsers for which grants may be made nnder this Act snch as, but not limited to, detoxification or other medical treatment, physical therapy, family counseling, psychotherapy, vocational training, help in finding employment, or probation-type supervision.

(b) The regulations referred to in subsection (a) may include provisions reqniring that (1) before approval of any application for a project pursuant to a State plan is recommended by any Agency, an assnrance shall be received, by the State filing such plan, from the applicant that a reasonable volume of treatment and rehabilitation services for drug abusers shall be made available to such drug abusers who are unable to pay for such services; and (2) each application filed by a nonprofit organization for financial assistance under clause (2) of subsection (b) of section 19 of this Act contain an assurance that a reasonable volume of such services shall be made available to such drug abusers who are unable to pay for snch services.

SEC. 21. (a) After the regulations referred to in section 20 have been issued, any State desiring to secure financial assistance under clause (1) of subsection (b) of section 19 of this Act shall submit a State plan for carrying ont the purposes of snch clause. Such State plan must—

(1) set forth a program for providing for treatment and rehabilitation services for drug abnsers which conforms with the regulations prescribed nnder section 20;

(2) designate a single State agency (referred to in this Act as the "Agency") as the sole agency for snpervising the administration of the plan;

(3) contain satisfactory evidence that the Agency will have anthority sufficient to carry out snch plan in conformity with this Act;

(4) provide such methods of administration of the State plan, incinding methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tennre of office, or compensation of any individnal employed in accordance with snch methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(5) provide that the Agency will make snch reports, in such form and containing such information, as the Secretary may from time to time reqnire, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of snch reports;

(6) provide for affording to every applicant for a grant for a project pnrsnant to a State plan an opportunity for hearing before the Agency;

(7) provide that the State will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) Any State desiring to submit a State plan as provided nnder subsection (a) shall submit snch plan as a separate and distinct part of its State mental health plan submitted to the Public Health Service by the State's mental health authority in accordance with title III of the Public Health Service Act.

(c) The Secretary may approve any State plan (and any modification thereof) which is in substantial conformity with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

SEC. 22. (a) Any State, political subdivision of a State, or nonprofit organization desiring to secure financial assistance for any project for the treatment and rehabilitation of drug abusers pursuant to an approved State plan shall submit, throngh the Agency, an application for a grant under this Act to assist it in carrying out such project. If any State, snbdivision, or organization jointly participate in any such project, the application may be filed by one or more of the participants. The application shall set forth—

(1) the kinds of treatment and rehabilitation services which will be provided under the project with respect to which such application is filed;

(2) reasonable assurances that the applicant is legally qualified and is competent to provide such services;

(3) reasonable assurances that the applicant will meet the requirements, if any, for furnishing treatment and rehabilitation services to drug abnsers who are unable to pay for such services; and

(4) such other information and assurances as the Secretary may, by regulation, require.

(b) The Secretary may approve any application filed nnder this section, if ne finds that the application (1) is in snbstantial conformity with subsection

(a) of this section and all applicable regulations issued pursuant to this Act, (2) is in substantial conformity with the State plan approved under section 21 of this Act, and (3) has been approved and recommended by the Agency. No application filed pursuant to this section shall be disapproved by the Secretary until he has afforded the applicant an opportunity for a hearing.

SEC. 23. (a) Any nonprofit organization desiring to secure financial assistance for any project for the treatment and rehabilitation of drug abusers as provided under clause (2) of subsection (b) of section 19 of this Act shall submit to the Secretary an application for a grant under such clause to assist it in carrying out such project. If two or more such organizations jointly participate in such project, the application may be filed by one or more of the participants. The application shall set forth—

(1) the kinds of treatment and rehabilitation services which will be provided under the project with respect to which such application is filed;

(2) an assurance that the applicant is legally qualified and is competent to provide such services;

(3) reasonable assurances that the applicant will meet the requirements, if any, for furnishing treatment and rehabilitation services to drug abusers who are unable to pay for such services; and

(4) such other information and assurances as the Secretary may, by regulation, require.

(b) The Secretary may approve any application filed under this section, if he finds (1) that the application is in substantial conformity with the provisions of subsection (a) of this section and all applicable regulations issued pursuant to this Act; and (2) after consultation with the Agency, that the application is not inconsistent with the State plan. No application filed pursuant to this section shall be disapproved by the Secretary until he has afforded the applicant an opportunity for a hearing.

(c) The Secretary may, by regulation, provide for regular reports to him by any recipient of a grant under this section.

SEC. 24. The payment of any grant to a State, political subdivision of a State, or nonprofit organization under this Act may follow the approval by the Secretary of the application of such State, subdivision, or organization. Such payment may be made by the Secretary in advance or by way of reimbursement, and in such installments as he may determine, and shall be made on such conditions as he finds necessary to carry out the purposes of this Act. Amounts paid under this Act with respect to any project covered by an application made under section 22 shall not exceed two-thirds of the cost of such project as determined by the Secretary.

SEC. 25. (a) There is hereby created an Advisory Committee on Drug Abuse (hereinafter referred to as the "Committee"), which shall consist of nine members appointed by the Secretary. Such members shall be appointed from among individuals concerned with the medical and social aspects of drug abuse and who are eminent in fields relating to the treatment and rehabilitation of drug abusers (including the field of research), such as psychiatry, psychology, general medical practice, pharmacology, internal medicine, vocational training, correctional rehabilitation, and law enforcement. Each member of the Committee shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and (2) the terms of the members of the first Committee appointed shall expire, as designated by the Secretary at the time of appointment, as follows: three at the end of sixteen months after their appointment, three at the end of thirty-two months after their appointment, and three at the end of four years after their appointment.

(b) It shall be the duty of the Committee to—

(1) advise, consult with, and make recommendations to the Secretary on matters relating to the administration of this Act;

(2) assist States desiring financial assistance under this Act in the preparation and filing of their State plans; and

(3) assist the Secretary in his carrying out of the purposes of section 301 of the Public Health Service Act with respect to narcotics by encouraging States, local agencies, laboratories, public and nonprofit agencies, and other qualified individuals to engage in research projects and collaborative studies, on a long-term-contract basis, into all aspects of drug abuse with a view to obtaining information, facts, and other data necessary to enable the various

governmental entities and private agencies to meet and combat the many problems resulting from drug abuse.

(c) Members of the Committee, not otherwise in the employ of the United States, while attending meetings of the Committee or while otherwise serving at the request of the Secretary, shall be entitled to receive compensation at a rate to be fixed by the Secretary, but not exceeding $75 per diem, including travel time; and while away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons in the government service employed intermittently.

(d) The Committee shall elect a Chairman from among its members, and shall be provided, by the Secretary, with such technical, consultative, clerical, and other assistance as he determines necessary to enable it to carry out its duties under this section.

SEC. 26. (a) Whenever the Secretary, after reasonable notice and opportunity for hearing to the Agency, finds—

(1) that the Agency is not complying substantially with the provisions required by subsection (a) of section 21 to be included in its State plan, or with regulations under this Act;

(2) that any assurance required to be given in an application filed under subsection (a) of section 22 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out the treatment and rehabilitation services approved by the Secretary under section 22;

the Secretary may forthwith notify such Agency that no further payments will be made under this Act for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph 1, 2, or 3 of this subsection; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments in connection with such State plan may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurances or services, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

(b) Whenever the Secretary, after reasonable notice and opportunity for hearing to any nonprofit organization, which is the recipient of a grant under clause (2) of subsection (h) of section 19 of this Act, finds—

(1) that such recipient is not complying substantially with the provisions required by section 23 of this Act to be included in its application for such grant, or with regulations under this Act;

(2) that any assurance required to be given in such application filed under section 23 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out the treatment and rehabilitation services approved by the Secretary under section 23;

the Secretary may forthwith notify the recipient that no further payments will be made under this Act for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), or (3) of this subsection; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments under this Act to such recipent may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurances or services, as the case may be) or, if such compliance (or other action) is impossible, until the recipient repays the moneys to which it was not entitled.

SEC. 27. (a) In providing technical assistance pursuant to this Act, the Secretary is authorized to make studies with respect to matters relating to the treatment and rehabilitation of drug abusers, including the effectiveness of projects financed in whole or in part by grants made pursuant to this Act, to cooperate with and render technical assistance to States, political subdivisions of States, and nonprofit organizations with respect to such matters, and to provide short-term training and instruction in technical matters relating to the treatment and rehabilitation of drug abusers.

(b) The Secretary is authorized to collect, evaluate, publish, and disseminate information and materials relating to studies conducted pursuant to this Act, and to such other matters involving the treatment and rehabilitation of drug abusers as the Secretary may determine feasible. The Secretary may, to the extent he determines appropriate, make such information and materials available to the general public or to any agency or other organization concerned with, or engaged in, the treatment and rehabilitation of drug abusers.

SEC. 28. In any case in wbich a State is dissatisfied with the actions of the Secretary under sectlon 21(c), 22(b), or 26(a), or in wbich a nonprofit organization is dissatisfied with his actions under sectlon 23(b) or 26(b), such State or organization, as the case may be, may appeal to the United States court of appeals for the circuit in which such State or organization is located, by filing a petitlon with such court within sixty days after such action. A copy of the petition shall be forthwith transmltted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the conrt the record of the proceedings on which be based his action, as provided In section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, In whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Sucb new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The jndgment of the court affirming or setting aside, in wbole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

SEC. 29. Section 341 of tbe Public Health Service Act (58 Stat. 682) is amended (1) by inserting immediately after "discipline of persons" the following: "who are physically or psychologically"; and (2) by inserting at the end of the first paragraph thereof the following new sentence: "Such hospitals shall, in addition to providing such care and treatment, engage in research, training, and demonstration in the techniques of treatment and social rehabilitation of addicts."

SEC. 30. Paragrapb (j) of section 2 of the Public Healtb Service Act is amended by adding at the end thereof the following: "any drug which contains any quantity of (A) barbituric acid or any of the salts of barbituric acid, or (B) any derivative of barbituric acid which has been designated by the Secretary nnder section 502(d) of the Federal Food, Drug, and Cosmetic Act as habit forming; any drug which contains any qnantity of (A) amphetamine or any of its optical isomers; (B) any salt of amphetamine or any salt of an optical isomer of amphetamine, or (C) any substance which the Secretary, after investigation, has found to be, and by regulation designated as, habit forming because of its stimulant effect on the central nervous system; any drug which contains any quantity of a substance wbich the Secretary, after investigation, finds, and by regulation designates as a substance wbicb (A) affects or alters to a substantive extent, consciousness, tbe ability to think, critical judgment, motivation, mood, psychomotor coordination, or sensory perception, and (B)(i) is substantially involved in drug abuse ('drug abuse' being deemed to exist when drugs are used for their psychotoxic effects alone and not as tberapeutic media prescribed in the course of medical treatment or when they are obtained through illicit channels), or (ii) has a substantial potential for such abuse by reason of the similarity of its effect to that of a drug already subject to this paragrapb ;".

SEC. 31. Paragraph (k) of section 2 of the Public Health Service Act is amended by adding at the end thereof the following: "or any person who repeatedly uses, on a periodic or continuous basis, for their psychotoxic effects alone and not as therapeutic media prescribed in tbe course of legitimate medical treatment, any drug or drugs, capable of altering or affecting, to a substantive degree, the consciousness, mood, motivation, or critical jndgment of an individnal, or the psychomotor coordination or the perception of the auditory or visnal sense of an individual;".

DEFINITIONS

SEC. 32. As nsed in this Act, tbe term—

(1) "State" shall include the District of Colnmbia;

(2) "drug abuser" means any person who repeatedly uses, on a periodic or continnous basis, for their psychotoxic effects alone and not as therapentic media prescribed in the course of legitimate medical treatment,

any drug or drugs capable of altering or affecting, to a substantive degree, the consciousness, mood, motivation, or critical judgment of an individual, or the psychomotor coordination or the perception of the auditory or visual sense of an individual. Such drugs shall include, without limitation thereto, the opiates, cocaine, marihuana, barbiturates, and amphetamines, but shall not include alcohol;

(3) "facilities" means buildings or other facilities which are operated for the primary purpose of assisting in the treatment and rehabilitation of drug abusers by providing under competent professional supervision, detoxification or other medical treatment, physical therapy, family counseling, psychotherapy, vocational training, help in finding employment, or other services. The term "facilities" shall include, among others, facilities for medical care, laboratories, community clinics, halfway houses, sheltered workshops, and camps;

(4) "construction" includes the creation of new buildings, acquisition, expansion, remodeling, and alteration of existing buildings, and payment of architect's fees. The term "construction" does not include the cost of offsite improvements and acquisitions of land.

[H.R. 9167, 89th Cong., 1st sess.]

A BILL To amend title 18 of the United States Code to enable the courts to deal more effectively with the problem of narcotic addiction, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congres assembled, That titles I and II of this Act may be cited as the "Narcotic Addict Rehabilitation Act of 1965".

DECLARATION OF POLICY

SEC. 2. It is the policy of the Congress that certain individuals charged with, or convicted of, violating Federal laws should be afforded an opportunity for treatment if it is determined that they are narcotic addicts and such treatment is likely to result in their rehabilitation and return to society as useful members. It is the further policy of the Congress that alternative procedures should be afforded for use in sentencing certain individuals convicted of violating Federal laws relating to narcotic drugs or marihuana.

TITLE I—CIVIL COMMITMENT IN LIEU OF PROSECUTION

DEFINITIONS

SEC. 101. As used in this title—

(a) "Addict" means any individual who habitually uses any narcotic drug as defined by section 4731 of the Internal Revenue Code of 1954, as amended, so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

(b) "Surgeon General" means the Surgeon General of the Public Health Service.

(c) "Crime of violence" includes voluntary manslaughter, murder, rape, mayhem, kidnaping, robbery, burglary, housebreaking, extortion accompanied by threats of violence, assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for more than one year, arson punishable as a felony, or an attempt to commit any of the foregoing offenses.

(d) "Treatment" includes treatment in an institution and under supervised aftercare in the community and includes, but is not limited to, medical, educational, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by correcting his antisocial tendencies and ending his dependence on addicting drugs and his susceptibility to addiction.

(e) "Felony" includes any offense in violation of a law of the United States, any State, any possession or territory of the United States, the District of Columbia, the Canal Zone, or the Commonwealth of Puerto Rico, which at the time of the offense was punishable by death or imprisonment for a term exceeding one year.

(f) "Conviction" and "convicted" mean the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere, but do not include a final judgment which has been expunged by pardon, reversed, set aside or otherwise rendered nugatory.

(g) "Eligible individual" means any individual who is charged with an offense against the United States, but does not include—

(1) An individual charged with a crime of violence.

(2) An individual charged with selling a narcotic drug, unless the court determines that such sale was for the primary purpose of enabling the individual to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug.

(3) An individual against whom there is pending a prior charge of a felony which has not been finally determined or who is on probation or whose sentence following conviction on such a charge, including any time on parole or mandatory release, has not been fully served: *Provided*, That an individual on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment.

(4) An individual who has been convicted of a felony on two or more occasions.

(5) An individual who has been civilly committed under this Act or any State proceeding because of narcotic addiction on two or more occasions.

PROCEEDINGS BEFORE COURT

SEC. 102. (a) If the United States district court believes that an eligible individual is an addict, the court may advise him at his first appearance that the prosecution of the criminal charge will be held in abeyance if he elects to submit to an immediate examination to determine whether he is an addict and is likely to be rehabilitated through treatment. In offering an individual an election, the court shall advise him that if he elects to be examined, he will be confined during the examination for a period not to exceed sixty days; that if he is determined to be an addict who is likely to be rehabilitated, he will be civilly committed to the Surgeon General for treatment; that he may not voluntarily withdraw from the examination or any treatment which may follow; that the treatment may last for thirty-six months; that during treatment, he will be confined in an institution and, at the discretion of the Surgeon General, he may be conditionally released for supervised aftercare treatment in the community; and that if he successfully completes treatment the charge will be dismissed, but if he does not, prosecution on the charge will be resumed. An individual shall be permitted a maximum of five days after his appearance in which to elect, and he shall be so advised. Except on a showing that a timely election could not have been made, an individual shall be barred from an election after the prescribed period. An individual who elects civil commitment shall be placed in the custody of the Attorney General or the Surgeon General, as the court directs, for an examination by the Surgeon General during a period not to exceed thirty days. This period may, upon notice to the court and the appropriate United States attorney, be extended by the Surgeon General for an additional thirty days.

(b) The Surgeon General shall report to the court the results of the examination and recommend whether the individual should be civilly committed. A copy of the report shall be made available to the individual and the United States attorney. If the court, acting on the report and other information coming to its attention, determines that the individual is not an addict or is an addict not likely to be rehabilitated through treatment, the individual shall be held to answer the abeyant charge. If the court determines that the individual is an addict and is likely to be rehabilitated through treatment, the court shall commit him to the custody of the Surgeon General for treatment. No individual shall be committed under this title if the Surgeon General certifies that adequate facilities or personnel for treatment are unavailable.

(c) Whenever an individual is committed to the custody of the Surgeon General for treatment under this title, the criminal charge against him shall be continued without final disposition and shall be dismissed if the Surgeon General certifies to the court that the individual has successfully completed the treatment program. On receipt of such certification, the court shall discharge the individual from custody. If prior to such certification the Surgeon General

determines that the individual cannot be further treated as a medical problem, he shall advise the court. The court shall thereupon terminate the commitment, and the pending criminal proceeding shall be resumed.

(d) An individual committed for examination or treatment shall not be released on bail or on his own recognizance.

COMMITMENT

SEC. 103. (a) An individual who is committed to the custody of the Surgeon General for treatment under this title shall not be conditionally released from institutional custody until the Surgeon General determines that he has made sufficient progress to warrant release to a supervisory aftercare authority. If the Surgeon General is unable to make such a determination at the expiration of twenty-four months after the commencement of institutional custody, he shall advise the court and the appropriate United States attorney whether treatment should be continued. The court may affirm the commitment or terminate it and resume the pending criminal proceeding.

(b) An individual who is conditionally released from institutional custody shall, while on release, remain in the legal custody of the Surgeon General and shall report for such supervised aftercare treatment as the Surgeon General directs. He shall be subject to home visits and to such physical examination and reasonable regulation of his conduct as the supervisory aftercare authority establishes, subject to the approval of the Surgeon General. The Surgeon General may, at any time, order a conditionally released individual to return for institutional treatment. The Surgeon General's order shall be a sufficient warrant for the supervisory aftercare authority, a United States marshal, a probation officer, or an agent of the Attorney General, to apprehend and return the individual to institutional custody as directed. If it is determined that an individual has returned to the use of narcotics, the Surgeon General shall inform the court of the conditions under which the return occurred and make a recommendation as to whether treatment should be continued. The court may affirm the commitment or terminate it and resume the pending criminal proceeding.

(c) The total period of treatment for any individual committed to the custody of the Surgeon General shall not exceed thirty-six months. If, at the expiration of such maximum period, the Surgeon General is unable to certify that the individual has successfully completed his treatment program the pending criminal proceeding shall be resumed.

(d) Whenever a pending criminal proceeding against an individual is resumed under this title, he shall receive full credit towad the service of any sentence which may be imposed for any time spent in the institutional custody of the Surgeon General or the Attorney General or any other time spent in institutional custody in connection with the matter for which sentence is imposed.

CIVIL COMMITMENT NOT TO BE A CONVICTION

SEC. 104. The determination of narcotic addiction and the subsequent civil commitment under this title shall not be deemed a criminal conviction. The results of any tests or procedures conducted by the Surgeon General or the supervisory aftercare authority to determine narcotic addiction may only be used in a further proceeding under this title. They shall not be used against the examined individual in any criminal proceeding except that the fact that he is a narcotic addict may be elicited on his cross-examination as bearing on his credibility as a witness.

USE OF FEDERAL, STATE, AND PRIVATE FACILITIES

SEC. 105. (a) The Surgeon General may from time to time make such provision as he deems appropriate authorizing the performance of any of his functions under this title by any other officer or employee of the Public Health Service, or with the consent of the head of the Department or Agency concerned, by any Federal or other public or rivate agency or officer or employee thereof.

(b) The Surgeon General is authorized to enter into arrangements with any public or private agency or any person under which appropriate facilities or services of such agency or person will be made available, on a reimbursable basis or otherwise, for the examination or treatment of individuals who elect civil commitment under this title.

TITLE II—SENTENCING TO COMMITMENT FOR TREATMENT

SEC. 201. Title 18 of the United States Code is amended by adding after chapter 313 thereof the following new chapter:

"CHAPTER 314—NARCOTIC ADDICTS

"Sec.
"4251. Definitions.
"4252. Examination.
"4253. Commitment.
"4254. Conditional Release.
"4255. Supervision in the Community.

"§ 4251. Definitions

"As used in this chapter—

"(a) 'Addict' means any individual who habitually uses any narcotic drug as defined by section 4731 of the Internal Revenue Code of 1954, as amended, so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

"(b) 'Crime of violence' includes voluntary manslaughter, murder, rape, mayhem, kidnaping, robbery, burglary, housebreaking, extortion accompanied by threats of violence, assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for more than one year, arson punishable as a felony, or an attempt to commit any of the foregoing offenses.

"(c) 'Treatment' includes treatment in an institution and under supervised aftercare in the community and includes, but is not limited to, medical, educational, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by correcting his antisocial tendencies and ending his dependence on addicting drugs and his susceptibility to addiction.

"(d) 'Felony' includes any offense in violation of a law of the United States, any State, any possession or territory of the United States, the District of Columbia, the Canal Zone, or the Commonwealth of Puerto Rico, which at the time of the offense was punishable by death or imprisonment for a term exceeding one year.

"(e) 'Conviction' and 'convicted' mean the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere, and do not include a final judgment which has been expunged by pardon, reversed, set aside, or otherwise rendered nugatory.

"(f) 'Eligible offender' means any individual who is convicted of an offense against the United States, but does not include—

"(1) An offender who is convicted of a crime of violence.

"(2) An offender who is convicted of selling a narcotic drug, unless the court determines that such sale was for the primary purpose of enabling the offender to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug.

"(3) An offender against whom there is pending a prior charge of a felony which has not been finally determined or who is on probation or whose sentence following conviction on such a charge, including any time on parole or mandatory release, has not been fully served: *Provided*, That an offender on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment.

"(4) An offender who has been convicted of a felony on two or more prior occasions.

"(5) An offender who has been committed under title I of the Narcotic Addict Rehabilitation Act of 1965, under this chapter, or under any State proceeding because of narcotic addiction on two or more occasions.

"§ 4252. Examination

"If the court believes that an eligible offender is an addict, it may place him in the custody of the Attorney General for an examination to determine whether he is an addict and is likely to be rehabilitated through treatment. The Attorney General shall report to the court within thirty days; or any additional period granted by the court, the results of such examination and make any recommendations he deems desirable. No offender shall be committed under this chapter if the Attorney General certifies that adequate facilities or personnel for treatment are unavailable. An offender shall receive full credit toward the service of his sentence for any time spent in custody for an examination.

"§ 4253. Commitment

"(a) If the court determines that an eligible offender is an addict and is likely to be rehabilitated through treatment, it shall commit him to the custody of the Attorney General for treatment under this chapter. Such commitment shall be for an indeterminate period of time not to exceed ten years, but in no event shall it exceed the maximum sentence that could otherwise have been imposed.

"(b) If the court determines that an eligible offender is not an addict, or is an addict not likely to be rehabilitated through treatment, it shall impose such other sentence as may be authorized or required by law.

"§ 4254. Conditional release

"An offender committed under section 4253(a) may not be conditionally released until he has been treated for six months in an institution maintained or approved by the Attorney General for treatment. The Attorney General may then or at any time thereafter report to the Board of Parole whether the offender should be conditionally released under supervision After receipt of the Attorney General's report, and certification from the Surgeon General of the Public Health Service that the offender has made sufficient progress to warrant his conditional release under supervision, the Board may in its discretion order such a release. In determining suitability for release, the Board may make any investigation it deems necessary. If the Board does not conditionally release the offender, or if a conditional release is revoked, the Board may thereafter grant a release on receipt of a further report from the Attorney General.

"§ 4255. Supervision in the community

"An offender who has been conditionally released shall be under the jurisdiction of the Board as if on parole under the established rules of the Board and shall remain, while conditionally released, in the legal custody of the Attorney General. The Attorney General may contract with any appropriate public or private agency or any person for supervisory aftercare of a conditionally released offender. Upon receiving information that such an offender has violated his conditional release, the Board, or a member thereof, may issue and cause to be executed a warrant for his apprehension and return to custody. Upon return to custody, the offender shall be given an opportunity to appear before the Board, a member thereof, or an examiner designated by the Board, after which the Board may revoke the order of conditional release."

TITLE III—SENTENCING AFTER CONVICTION FOR VIOLATION OF LAW RELATING TO NARCOTIC DRUGS OR MARIHUANA

SEC. 301. Section 7 of the joint resolution of August 25, 1958 (72 Stat. 845), is amended to read as follows:

"SEC. 7. This Act does not apply to any offense for which a mandatory penalty is provided; except that section 4209 of title 18, as amended, shall apply to any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended."

SEC. 302. Section 4209 of title 18, United States Code, is amended by (1) inserting immediately before the first sentence thereof "(a)" and (2) adding at the end thereof the following new subsections:

"(b) A defendant described in subsection (a) of this section who is convicted of a violation of any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended, shall, if the court is considering sentencing him to the custody of the Attorney General pursuant to the provisions of the Federal Youth Corrections Act, be committed to the custody of the Attorney General for observation and study in accordance with the provisions of section 5010(e) of this title. Before sentencing such a defendant to the custody of the Attorney General for treatment and supervision pursuant to the Federal Youth Corrections Act, the court must affirmatively find, in writing, that there is reasonable ground to believe that the defendant will benefit from the treatment provided thereunder."

"(c) Section 5010(a) of this title shall not be applicable to a defendant described in subsection (a) of this section who is convicted of a violation of any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended."

SEC. 303. Section 7237(d) of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(d) NO SUSPENSION OF SENTENCE; NO PROBATION; ETC.—Upon conviction—

"(1) of any offense the penalty for which is provided in subsection (h) of this section, subsection (c), (h), or (i) of section 2 of the Narcotic Drugs Import and Export Act, as amended, or such Act of July 11, 1941, as amended, or

"(2) of any offense the penalty for which is provided in subsection (a) of this section, if it is the offender's second or subsequent offense,

the imposition or execution of sentence shall not be suspended, probation shall not be granted, and in the case of a violation of a law relating to narcotic drugs, section 4202 of title 18, United States Code, and the Act of July 15, 1932 (47 Stat. 696; D.C. Code 24–201 and following), as amended, shall not apply."

SEC. 304. The Board of Parole is hereby directed to review the sentence of any prisoner who, before the enactment of this Act, was made ineligible for parole by section 7237(d) of the Internal Revenue Code of 1954, as amended, and (1) who was convicted of a violation of a law relating to marihuana or (2) who was convicted of a violation of a law relating to narcotic drugs and had not attained his twenty-sixth birthday prior to such conviction. After conducting such review the Board of Parole may authorize the release of such prisoner on parole pursuant to section 4202 of title 18, United States Code. If the Board of Parole finds that there are reasonable grounds to believe that such prisoner may benefit from the treatment provided under the Federal Youth Corrections Act (18 U.S.C., ch. 402), it may place such prisoner in the custody of the Youth Corrections Division of the Board of Parole for treatment and supervision pursuant to the provisions of the Federal Youth Corrections Act. Action taken by the Board of Parole under this section shall not cause any prisoner to serve a longer term than would be served under his original sentence.

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. Section 341 of the Public Health Service Act, as amended (58 Stat. 698; 68 Stat. 80; 70 Stat. 622; 42 U.S.C. 257), is amended to read as follows:

"SEC. 341. (a) The Surgeon General is authorized to provide for the confinement, care, protection, treatment, and discipline of persons addicted to the use of habit-forming narcotic drugs who are civilly committed to treatment or convicted of offenses against the United States and sentenced to treatment under the Narcotic Addict Rehabilitation Act of 1965, addicts who are committed to the custody of the Attorney General pursuant to the provisions of the Federal Youth Corrections Act, addicts who voluntarily submit themselves for treatment, and addicts convicted of offenses against the United States and who are not sentenced to treatment under the Narcotic Addict Rehabilitation Act of 1965, including persons convicted by general courts-martial and consular courts. Such care and treatment shall be provided at hospitals of the Service especially equipped for the accommodation of such patients or elsewhere where authorized under other provisions of law, and shall be designed to rehabilitate such persons, to restore them to health, and, where necessary, to train them to be self-supporting and self-reliant, but nothing in this section or in this part shall be construed to limit the authority of the Surgeon General under other provisions of law to provide for the conditional release of patients and aftercare under supervision.

"(b) Upon the admittance to, and departure from, a hospital of the service of a person who voluntarily submitted himself for treatment pursuant to the provisions of this section, and who at the time of his admittance to such hospital was a resident of the District of Columbia, the Surgeon General shall furnish to the Commissioners of the District of Columbia or their designated agent, the name, address, and such other pertinent information as may be useful in the rehabilitation to society of such person."

SEC. 402. The Surgeon General and the Attorney General are authorized to give representatives of States and local subdivisions thereof the benefit of their experience in the care, treatment, and rehabilitation of narcotic addicts so that each State may be encouraged to provide adequate facilities and personnel for the care and treatment of narcotic addicts in its jurisdiction.

SEC. 403. The table of contents to "PART III.—PRISONS AND PRISONERS" of title 18, United States Code, is amended by inserting after

"313. Mental defectives ..... 4241"

a new chapter reference as follows:

"314. Narcotic addicts ..... 4251"

SEC. 404. If any provision of this Act or the application thereof to any person or circumstance is held invalid, the remainder of the Act and the application of such provision to other persons not similarly situated or to other circumstances shall not be affected thereby.

SEC. 405. Title I of this Act shall take effect three months after the date of its enactment and shall apply to any case pending in a district court of the United States in which an appearance has not been made prior to such effective date. Titles II and III of this Act shall take effect on the date of its enactment and shall apply to any case pending in any court of the United States in which sentence has not yet been imposed as of the date of enactment.

SEC. 406. There are authorized to be appropriated such sums as are necessary to carry out the provisions of this Act.

[H.R. 9159, 89th Cong., 1st sess.]

A BILL To amend title 18 of the United States Code to enable the courts to deal more effectively with the problem of narcotic addiction, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That titles I and II of this Act may be cited as the "Narcotic Addict Rehabilitation Act of 1965".

DECLARATION OF POLICY

SEC. 2. It is the policy of the Congress that certain individuals charged with, or convicted of, violating Federal laws should be afforded an opportunity for treatment if it is determined that they are narcotic addicts and such treatment is likely to result in their rehabilitation and return to society as useful members. It is the further policy of the Congress that alternative procedures should be afforded for use in sentencing certain individuals convicted of violating Federal laws relating to narcotic drugs or marihuana.

TITLE I—CIVIL COMMITMENT IN LIEU OF PROSECUTION

DEFINITIONS

SEC. 101. As used in this title—

(a) "Addict" means any individual who habitually uses any narcotic drug as defined by section 4731 of the Internal Revenue Code of 1954, as amended, so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

(b) "Surgeon General" means the Surgeon General of the Public Health Service.

(c) "Crime of violence" includes voluntary manslaughter, murder, rape, mayhem, kidnapping, robbery, burglary, housebreaking, extortion accompanied by threats of violence, assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for more than one year, arson punishable as a felony, or an attempt to commit any of the foregoing offenses.

(d) "Treatment" includes treatment in an institution and under supervised aftercare in the community and includes, but is not limited to, medical, educational, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by correcting his antisocial tendencies and ending his dependence on addicting drugs and his susceptibility to addiction.

(e) "Felony" includes any offense in violation of a law of the United States, any State, any possession or territory of the United States, the District of Columbia, the Canal Zone, or the Commonwealth of Puerto Rico, which at the time of the offense was punishable by death or imprisonment for a term exceeding one year.

(f) "Conviction" and "convicted" means the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere, but do not include a final judgement which has been expunged by pardon, reversed, set aside or otherwise rendered nugatory.

(g) "Eligible individual" means any individual who is charged with an offense against the United States, but does not include—

(1) An individual charged with a crime of violence.

(2) An individual charged with selling a narcotic drug, unless the court determines that such sale was for the primary purpose of enabling the individual to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug.

(3) An individual against whom there is pending a prior charge of a felony which has not been finally determined or who is on probation or whose sentence following conviction on such a charge, including any time on parole or mandatory release, has not been fully served: *Provided*, That an individual on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment.

(4) An individual who has been convicted of a felony on two or more occasions.

(5) An individual who has been civilly committed under this Act or any State proceeding because of narcotic addiction on two or more occasions.

PROCEEDINGS BEFORE COURT

SEC. 102. (a) If a United States district court believes that an eligible individual is an addict, the court may advise him at his first appearance that the prosecution of the criminal charge will be held in abeyance if he elects to submit to an immediate examination to determine whether he is an addict and is likely to be rehabilitated through treatment. In offering an individual an election, the court shall advise him that if he elects to be examined, he will be confined during the examination for a period not to exceed sixty days; that if he is determined to be an addict who is likely to be rehabilitated, he will be civilly committed to the Surgeon General for treatment; that he may not voluntarily withdraw from the examination or any treatment which may follow; that the treatment may last for thirty-six months; that during treatment, he will be confined in an institution and, at the discretion of the Surgeon General, he may be conditionally released for supervised aftercare treatment in the community; and that if he successfully completes treatment the charge will be dismissed, but if he does not, prosecution on the charge will be resumed. An individual shall be permitted a maximum of five days after his appearance in which to elect, and he shall be so advised. Except on a showing that a timely election could not have been made, an individual shall be barred from an election after the prescribed period. An individual who elects civil commitment shall be placed in the custody of the Attorney General or the Surgeon General, as the court directs, for an examination by the Surgeon General during a period not to exceed thirty days. This period may, upon notice to the court and the appropriate United States attorney, be extended by the Surgeon General for an additional thirty days.

(b) The Surgeon General shall report to the court the results of the examination and recommend whether the individual should be civilly committed. A copy of the report shall be made available to the individual and the United States attorney. If the court, acting on the report and other information coming to its attention, determines that the individual is not an addict or is an addict not likely to be rehabilitated through treatment, the individual shall be held to answer the abeyant charge. If the court determines that the individual is an addict and is likely to be rehabilitated through treatment, the court shall commit him to the custody of the Surgeon General for treatment. No individual shall be committed under this title if the Surgeon General certifies that adequate facilities or personnel for treatment are unavailable.

(c) Whenever an individual is committed to the custody of the Surgeon General for treatment under this title, the criminal charge against him shall be continued without final disposition and shall be dismissed if the Surgeon General certifies to the court that the individual has successfully completed the treatment program. On receipt of such certification, the court shall discharge the individual from custody. If prior to such certification the Surgeon General determines that the individual cannot be further treated as a medical problem, he shall advise the court. The court shall thereupon terminate the commitment, and the pending criminal proceeding shall be resumed.

(d) An individual committed for examination or treatment shall not be released on bail or on his own recognizance.

COMMITMENT

SEC. 103. (a) An individual who is committed to the custody of the Surgeon General for treatment under this title shall not be conditionally released from institutional custody until the Surgeon General determines that he has made sufficient progress to warrant release to a supervisory aftercare authority. If the Surgeon General is unable to make such a determination at the expiration of twenty-four months after the commencement of institutional custody, he shall advise the court and the appropriate United States attorney whether treatment should be continued. The court may affirm the commitment or terminate it and resume the pending criminal proceeding.

(b) An individual who is conditionally released from institutional custody shall, while on release, remain in the legal custody of the Surgeon General and shall report for such supervised aftercare treatment as the Surgeon General directs. He shall be subject to home visits and to such physical examination and reasonable regulation of his conduct as the supervisory aftercare authority establishes, subject to the approval of the Surgeon General. The Surgeon General may, at any time, order a conditionally released individual to return for institutional treatment. The Surgeon General's order shall be a sufficient warrant for the supervisory aftercare authority, a United States marshal, a probation officer, or an agent of the Attorney General, to apprehend and return the individual to institutional custody as directed. If it is determined that an individual has returned to the use of narcotics, the Surgeon General shall inform the court of the conditions under which the return occurred and make a recommendation as to whether treatment should be continued. The court may affirm the commitment or terminate it and resume the pending criminal proceeding.

(c) The total period of treatment for any individual committed to the custody of the Surgeon General shall not exceed thirty-six months. If, at the expiration of such maximum period, the Surgeon General is unable to certify that the individual has successfully completed his treatment program the pending criminal proceeding shall be resumed.

(d) Whenever a pending criminal proceeding against an individual is resumed under this title, he shall receive full credit toward the service of any sentence which may be imposed for any time spent in the institutional custody of the Surgeon General or the Attorney General or any other time spent in institutional custody in connection with the matter for which sentence is imposed.

CIVIL COMMITMENT NOT TO BE A CONVICTION

SEC. 104. The determination of narcotic addiction and the subsequent civil commitment under this title shall not be deemed a criminal conviction. The results of any tests or procedures conducted by the Surgeon General or the supervisory aftercare authority to determine narcotic addiction may only be used in a further proceeding under this title. They shall not be used against the examined individual in any criminal proceeding except that the fact that he is a narcotic addict may be elicited on his cross-examination as bearing on his credibility as a witness.

USE OF FEDERAL, STATE, AND PRIVATE FACILITIES

SEC. 105. (a) The Surgeon General may from time to time make such provision as he deems appropriate authorizing the performance of any of his functions under this title by any other officer or employee of the Public Health Service, or with the consent of the head of the Department or Agency concerned, by any Federal or other public or private agency or officer or employee thereof.

(b) The Surgeon General is authorized to enter into arrangements with any public or private agency or any person under which appropriate facilities or services of such agency or person will be made available, on a reimbursable basis or otherwise, for the examination or treatment of individuals who elect civil commitment under this title.

TITLE II—SENTENCING TO COMMITMENT FOR TREATMENT

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"CHAPTER 314—NARCOTIC ADDICTS

"Sec.
"4251. Definitions.
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"4255. Supervision in the Community.

"§ 4251. Definitions

"As used in this chapter—

"(a) 'Addict' means any individual who habitually uses any narcotic drug as defined by section 4731 of the Internal Revenue Code of 1954, as amended, so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

"(b) 'Crime of violence' includes voluntary manslaughter, murder, rape, mayhem, kidnaping, robbery, burglary, housebreaking, extortion accompanied by threats of violence, assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for more than one year, arson punishable as a felony, or an attempt to commit any of the foregoing offenses.

"(c) 'Treatment' includes treatment in an institution and under supervised aftercare in the community and includes, but is not limited to, medical, educational, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by correcting his antisocial tendencies and ending his dependence on addicting drugs and his susceptibility to addiction.

'(d) 'Felony' includes any offense in violation of a law of the United States, any State, any possession or territory of the United States, the District of Columbia, the Canal Zone, or the Commonwealth of Puerto Rico, which at the time of the offense was punishable by death or imprisonment for a term exceeding one year.

"(e) 'Conviction' and 'convicted' mean the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere, and do not include a final judgment which has been expunged by pardon, reversed, set aside or otherwise rendered nugatory.

"(f) 'Eligible offender' means any individual who is convicted of an offense against the United States, but does not include—

"(1) An offender who is convicted of a crime of violence.

"(2) An offender who is convicted of selling a narcotic drug, unless the court determines that such sale was for the primary purpose of enabling the offender to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug.

"(3) An offender against whom there is pending a prior charge of a felony which has not been finally determined or who is on probation or whose sentence following conviction on such a charge, including any time on parole or mandatory release, has not been fully served: *Provided*, That an offender on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment.

"(4) An offender who has been convicted of a felony on two or more prior occasions.

"(5) An offender who has been committed under title I of the Narcotic Addict Rehabilitation Act of 1965, under this chapter, or under any State proceeding because of narcotic addition on two or more occasions.

"§ 4252. Examination

"If the court believes that an eligible offender is an addict, it may place him in the custody of the Attorney General for an examination to determine whether he is an addict and is likely to be rehabilitated through treatment. The Attorney General shall report to the court within thirty days; or any additional period granted by the court, the results of such examination and make any recommendations he deems desirable. No offender shall be committed under this chapter if

the Attorney General certifies that adequate facilities or personnel for treatment are unavailable. An offender shall receive full credit toward the service of his sentence for any time spent in custody for an examination.

"§ 4253. Commitment

"(a) If the court determines that an eligible offender is an addict and is likely to be rehabilitated through treatment, it shall commit him to the custody of the Attorney General for treatment under this chapter. Such commitment shall be for an indeterminate period of time not to exceed ten years, but in no event shall it exceed the maximum sentence that could otherwise have been imposed.

"(b) If the court determines that an eligible offender is not an addict, or is an addict not likely to be rehabilitated through treatment, it shall impose such other sentence as may be authorized or required by law.

"§ 4254. Conditional release

"An offender committed under section 4253(a) may not be conditionally released until he has been treated for six months in an institution maintained or approved by the Attorney General for treatment. The Attorney General may then or at any time thereafter report to the Board of Parole whether the offender should be conditionally released under supervision. After receipt of the Attorney General's report, and certification from the Surgeon General of the Public Health Service that the offender has made sufficient progress to warrant his conditional release under supervision, the Board may in its discretion order such a release. In determining suitability for release, the Board may make any investigation it deems necessary. If the Board does not conditionally release the offender, or if a conditional release is revoked, the Board may thereafter grant a release on receipt of a further report from the Attorney General.

"§ 4255. Supervision in the community

"An offender who has been conditionally released shall be under the jurisdiction of the Board as if on parole under the established rules of the Board and shall remain, while conditionally released, in the legal custody of the Attorney General. The Attorney General may contract with any appropriate public or private agency or any person for supervisory aftercare of a conditionally released offender. Upon receiving information that such an offender has violated his conditional release, the Board, or a member thereof, may issue and cause to be executed a warrant for his apprehension and return to custody. Upon return to custody, the offender shall be given an opportunity to appear before the Board, a member thereof, or an examiner designated by the Board, after which the Board may revoke the order of conditional release."

TITLE III—SENTENCING AFTER CONVICTION FOR VIOLATION OF LAW RELATING TO NARCOTIC DRUGS OR MARIHUANA

SEC. 301. Section 7 of the joint resolution of August 25, 1958 (72 Stat. 845) is amended to read as follows:

"SEC. 7. This Act does not apply to any offense for which a mandatory penalty is provided; except that section 4209 of title 18, as amended, shall apply to any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended."

SEC. 302. Section 4209 of title 18, United States Code, is amended by (1) inserting immediately before the first sentence thereof "(a)" and (2) adding at the end thereof the following new subsections:

"(b) A defendant described in subsection (a) of this section who is convicted of a violation of any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended, shall, if the court is considering sentencing him to the custody of the Attorney General pursuant to the provisions of the Federal Youth Corrections Act, be committed to the custody of the Attorney General for observation and study in accordance with the provisions of section 5010(e) of this title. Before sentencing such a defendant to the custody of the Attorney General for treatment and supervision pursuant to the Federal Youth Corrections Act, the court must affirmatively find, in writing, that there is reasonable ground to believe that the defendant will benefit from the treatment provided thereunder."

"(c) Section 5010(a) of this title shall not be applicable to a defendant described in subsection (a) of this section who is convicted of a violation of any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended."

SEC. 303. Section 7237(d) of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(d) NO SUSPENSION OF SENTENCE; NO PROBATION; ETC.—Upon conviction—

"(1) of any offense the penalty for which is provided in subsection (b) of this section, snbsection (c), (h), or (i) of section 2 of the Narcotic Drugs Import and Export Act, as amended, or such Act of July 11, 1941, as amended, or

"(2) of any offense the penalty for which is provided in subsection (a) of this section, if it is the offender's second or subsequent offense,

the imposition or execution of sentence shall not be suspended, probation shall not be granted, and in the case of a violation of a law relating to narcotic drugs, section 4202 of title 18, United States Code, and the Act of July 15, 1932 (47 Stat. 696; D.C. Code 24–201 and following), as amended, shall not apply."

SEC. 304. The Board of Parole is hereby directed to review the sentence of any prisoner who, before the enactment of this Act, was made ineligible for parole by section 7237(d) of the Internal Revenue Code of 1954, as amended, and (1) who was convicted of a violation of a law relating to marihuana or (2) who was convicted of a violation of a law relating to narcotic drugs and had not attained his 26th birthday prior to such conviction. After conducting such review the Board of Parole may authorize the release of such prisoner on parole pursuant to section 4202 of title 18, United States Code. If the Board of Parole finds that there are reasonable grounds to believe that such prisoner may benefit from the treatment provided under the Federal Youth Corrections Act (18 U.S.C., chapter 402), it may place such prisoner in the custody of the Youth Corrections Division of the Board of Parole for treatment and supervision pursuant to the provisions of the Federal Yonth Corrections Act. Action taken by the Board of Parole under this section shall not cause any prisoner to serve a longer term than would be served under his original sentence.

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. Section 341 of the Public Health Service Act, as amended (58 Stat. 698; 68 Stat. 80; 70 Stat. 622; 42 U.S.C. 257) is amended to read as follows:

"SEC. 341. (a) The Surgeon General is authorized to provide for the confinement, care, protection, treatment, and discipline of persons addicted to the use of habit-forming narcotic drugs who are civilly committed to treatment or convicted of offenses against the United States and sentenced to treatment under the Narcotic Addict Rehabilitation Act of 1965, addicts who are committed to the custody of the Attorney General pursuant to the provisions of the Federal Youth Corrections Act, addicts who voluntarily submit themselves for treatment, and addicts convicted of offenses against the United States and who are not sentenced to treatment under the Narcotic Addict Rehabilitation Act of 1965, incinding persons convicted by general courts-martial and consular courts. Such care and treatment shall be provided at hospitals of the Service especially equipped for the accommodation of such patients or elsewhere where authorized nnder other provisions of law, and shall be designed to rehabilitate such persons, to restore them to health, and, where necessary, to train them to be self-supporting and self-reliant, but nothing in this section or in this part shall be construed to limit the anthority of the Surgeon General under other provisions of law to provide for the conditional release of patients and aftercare under snpervision.

"(b) Upon the admittance to, and departure from, a hospital of the Service of a person who voluntarily submitted himself for treatment pursuant to the provisions of this section, and who at the time of his admittauce to such hospital was a resident of the District of Columbia, the Surgeon General shall furnish to the Commissioners of the District of Columbia or their designated agent, the name, address, and such other pertinent information as may be nseful in the rehabilitation to society of such person."

SEC. 402. The Surgeon General and the Attorney General are authorized to give representatives of States and local subdivisions thereof the benefit of their experience in the care, treatment, and rehabilitation of narcotic addicts so that each State may be encouraged to provide adeqnate facilities and personnel for the care and treatment of narcotic addicts in its jurisdiction.

SEC. 403. The table of contents to "PART III—PRISONS AND PRISONERS" of title 18, United States Code, is amended by inserting after

"313. Mental defectives ---------- 4241"

a new chapter reference as follows:

"314. Narcotic addicts ---------- 425[illegible]"

SEC. 404. If any provision of this Act or the application thereof to any person or circumstance is held invalid, the remainder of the Act and the application of such provision to other persons not similarly situated or to other circumstances shall not be affected thereby.

SEC. 405. Title I of this Act shall take effect three months after the date of its enactment and shall apply to any case pending in the district court of the United States in which an appearance has not been made prior to such effective date. Titles II and III of this Act shall take effect on the date of its enactment and shall apply to any case pending in any court of the United States in which sentence has not yet been imposed as of the date of enactment.

SEC. 406. There are authorized to be appropriated such sums as are necessary to carry out the provisions of this Act.

[H.R. 9249, 89th Cong., 1st sess.]

A BILL To amend title 18 of the United States Code to enable the courts to deal more effectively with the problem of narcotic addiction, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That titles I and II of this Act may be cited as the "Narcotic Addict Rehabilitation Act of 1965".

DECLARATION OF POLICY

SEC. 2. It is the policy of the Congress that certain individuals charged with, or convicted of, violating Federal laws should be afforded an opportunity for treatment if it is determined that they are narcotic addicts and such treatment is likely to result in their rehabilitation and return to society as useful members. It is the further policy of the Congress that alternative procedures should be afforded for use in sentencing certain individuals convicted of violating Federal laws relating to narcotic drugs or marihuana.

TITLE I—CIVIL COMMITMENT IN LIEU OF PROSECUTION

DEFINITIONS

SEC. 101. As used in this title—

(a) "Addict" means any individual who habitually uses any narcotic drug as defined by section 4731 of the Internal Revenue Code of 1954, as amended, so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

(b) "Surgeon General" means the Surgeon General of the Public Health Service.

(c) "Crime of violence" includes voluntary manslaughter, murder, rape, mayhem, kidnapping, robbery, burglary, housebreaking, extortion accompanied by threats of violence, assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for more than one year, arson punishable as a felony, or an attempt to commit any of the foregoing offenses.

(d) "Treatment" includes treatment in an institution and under supervised aftercare in the community and includes, but is not limited to, medical, educational, social, phychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by correcting his antisocial tendencies and ending his dependence on addicting drugs and his susceptibility to addiction.

(e) "Felony" includes any offense in violation of a law of the United States, any State, any possession or territory of the United States, the District of Columbia, the Canal Zone, or the Commonwealth of Puerto Rico, which at the time of the offense was punishable by death or imprisonment for a term exceeding one year.

(f) "Conviction" and "convicted" means the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere, but do not include a final judgment which has been expunged by pardon, reversed, set aside, or otherwise rendered nugatory.

(g) "Eligible individual" means any individual who is charged with an offense against the United States, but does not include—

(1) An individual charged with a crime of violence.

(2) An individual charged with selling a narcotic drug, unless the court determines that such sale was for the primary purpose of enabling the individual to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug.

(3) An individual against whom there is pending a prior charge of a felony which has not been finally determined or who is on probation or whose sentence following conviction on such a charge, including any time on parole or mandatory release, has not been fully served: *Provided*, That an individual on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment.

(4) An individual who has been convicted of a felony on two or more occasions.

(5) An individual who has been civilly committed under this Act or any State proceeding because of narcotic addiction on two or more occasions.

PROCEEDINGS BEFORE COURT

SEC. 102. (a) If a United States district court believes that an eligible individual is an addict, the court may advise him at this first appearance that the prosecution of the criminal charge will be held in abeyance if he elects to submit to an immediate examination to determine whether he is an addict and is likely to be rehabilitated through treatment. In offering an individual an election, the court shall advise him that if he elects to be examined, he will be confined during the examination for a period not to exceed sixty days; that if he is determined to be an addict who is likely to be rehabilitated, he will be civilly committed to the Surgeon General for treatment; that he may not voluntarily withdraw from the examination or any treatment which may follow; that the treatment may last for thirty-six months; that during treatment, he will be confined in an institution and, at the discretion of the Surgeon General, he may be conditionally released for supervised aftercare treatment in the community; and that if he successfully completes treatment the charge will be dismissed, but if he does not, prosecution on the charge will be resumed. An individual shall be permitted a maximum of five days after his appearance in which to elect, and he shall be so advised. Except on a showing that a timely election could not have been made, an individual shall be barred from an election after the prescribed period. An individual who elects civil commitment shall be placed in the custody of the Attorney General or the Surgeon General, as the court directs, for an examination by the Surgeon General during a period not to exceed thirty days. This period may, upon notice to the court and the appropriate United States attorney, be extended by the Surgeon General for an additional thirty days.

(b) The Surgeon General shall report to the court the results of the examination and recommend whether the individual should be civilly committed. A copy of the report shall be made available to the individual and the United States attorney. If the court, acting on the report and other information coming to its attention, determines that the individual is not an addict or is an addict not likely to be rehabilitated through treatment, the individual shall be held to answer the abeyant charge. If the court determines that the individual is an addict and is likely to be rehabilitated through treatment, the court shall commit him to the custody of the Surgeon General for treatment. No individual shall be committed under this title if the Surgeon General certifies that adequate facilities or personnel for treatment are unavailable.

(c) Whenever an individual is committed to the custody of the Surgeon General for treatment under this title, the criminal charge against him shall be continued without final disposition and shall be dismissed if the Surgeon General certifies to the court that the individual has successfully completed the treatment program. On receipt of such certification the court shall discharge the individual from custody. If prior to such certification the Surgeon General determines that the individual cannot be further treated as a medical problem, he shall advise the court. The court shall thereupon terminate the commitment, and the pending criminal proceeding shall be resumed.

(d) An individual committed for examination or treatment shall not be released on bail or on his own recognizance.

COMMITMENT

SEC. 103. (a) An individual who is committed to the custody of the Surgeon General for treatment under this title shall not be conditionally released from institutional custody until the Surgeon General determines that he has made sufficient progress to warrant release to a supervisory aftercare authority. If the Surgeon General is unable to make such a determination at the expiration of twenty-four months after the commencement of institutional custody, he shall advise the court and the appropriate United States attorney whether treatment should be continued. The court may affirm the commitment or terminate it and resume the pending criminal proceeding.

(b) An individual who is conditionally released from institutional custody shall, while on release, remain in the legal custody of the Surgeon General and shall report for such supervised aftercare treatment as the Surgeon General directs. He shall be subject to home visits and to such physical examination and reasonable regulation of his conduct as the supervisory aftercare authority establishes, subject to the approval of the Surgeon General. The Surgeon General may, at any time, order a conditionally released individual to return for institutional treatment. The Surgeon General's order shall be a sufficient warrant for the supervisory aftercare authority, a United States marshal, a probation officer, or an agent of the Attorney General, to apprehend and return the individual to institutional custody as directed. If it is determined that an individual has returned to the use of narcotics, the Surgeon General shall inform the court of the conditions under which the return occurred and make a recommendation as to whether treatment should be continued. The court may affirm the commitment or terminate it and resume the pending criminal proceeding.

(c) The total period of treatment for any individual committed to the custody of the Surgeon General shall not exceed thirty-six months. If, at the expiration of such maximum period, the Surgeon General is unable to certify that the individual has successfully completed his treatment program the pending criminal proceeding shall be resumed.

(d) Whenever a pending criminal proceeding against an individual is resumed under this title, he shall receive full credit toward the service of any sentence which may be imposed for any time spent in the institutional custody of the Surgeon General or the Attorney General or any other time spent in institutional custody in connection with the matter for which sentence is imposed.

CIVIL COMMITMENT NOT TO BE A CONVICTION

SEC. 104. The determination of narcotic addiction and the subsequent civil commitment under this title shall not be deemed a criminal conviction. The results of any tests or procedures conducted by the Surgeon General or the supervisory aftercare authority to determine narcotic addiction may only be used in a further proceeding under this title. They shall not be used against the examined individual in any criminal proceeding except that the fact that he is a narcotic addict may be elicited on his cross-examination as bearing on his credibility as a witness.

USE OF FEDERAL, STATE, AND PRIVATE FACILITIES

SEC. 105. (a) The Surgeon General may from time to time make such provision as he deems appropriate authorizing the performance of any of his functions under this title by any other officer or employee of the Public Health Service, or with the consent of the head of the department or agency concerned, by any Federal or other public or private agency or officer or employee thereof.

(b) The Surgeon General is authorized to enter into arrangements with any public or private agency or any person under which appropriate facilities or services of such agency or person will be made available, on a reimbursable basis or otherwise, for the examination or treatment of individuals who elect civil commitment under this title.

TITLE II—SENTENCING TO COMMITMENT FOR TREATMENT

SEC. 201. Title 18 of the United States Code is amended by adding after chapter 313 thereof the following new chapter:

"CHAPTER 314—NARCOTIC ADDICTS

"Sec.
"4251. Definitions.
"4252. Examination.
"4253. Commitment.
"4254. Conditional release.
"4255. Supervision in the community.

"§ 4251. Definitions

"As used in this chapter—

"(a) 'Addict' means any individual who habitually uses any narcotic drug as defined by section 4731 of the Internal Revenue Code of 1954, as amended, so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

"(b) 'Crime of violence' includes voluntary manslaughter, murder, rape, mayhem, kidnaping, robbery, burglary, housebreaking, extortion accompanied by threats of violence, assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for not more than one year, arson punishable as a felony, or an attempt to commit any of the foregoing offenses.

"(c) 'Treatment' includes treatment in an institution and under supervised aftercare in the community and includes, but is not limited to, medical, educational, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by correcting his antisocial tendencies and ending his dependence on addicting drugs and his susceptibility to addiction.

"(d) 'Felony' includes any offense in violation of a law of the United States, any State, any possession or territory of the United States, the District of Columbia, the Canal Zone, or the Commonwealth of Puerto Rico, which at the time of the offense was punishable by death or imprisonment for a term exceeding one year.

"(e) 'Conviction' and 'convicted' mean the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere, and do not include a final judgment which has been expunged by pardon, reversed, set aside or otherwise rendered nugatory.

"(f) 'Eligible offender' means any individual who is convicted of an offense against the United States, but does not include—

"(1) An offender who is convicted of a crime of violence.

"(2) An offender who is convicted of selling a narcotic drug, unless the court determines that such sale was for the primary purpose of enabling the offender to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug.

"(3) An offender against whom there is pending a prior charge of a felony which has not been finally determined or who is on probation or whose sentence following conviction on such a charge, including any time on parole or mandatory release, has not been fully served: *Provided*, That an offender on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment.

"(4) An offender who has been convicted of a felony on two or more prior occasions.

"(5) An offender who has been committed under title I of the Narcotic Addict Rehabilitation Act of 1965, under this chapter, or under any State proceeding because of narcotic addiction on two or more occasions.

"§ 4252. Examination

"If the court believes that an eligible offender is an addict, it may place him in the custody of the Attorney General for an examination to determine whether he is an addict and is likely to be rehabilitated through treatment. The Attorney General shall report to the court within thirty days; or any additional period granted by the court, the results of such examination and make any recommendations he deems desirable. No offender shall be committed under this chapter if the Attorney General certifies that adequate facilities or

personnel for treatment are unavailable. An offender shall receive full credit toward the service of his sentence for any time spent in custody for an examination.

"§ 4253. Commitment

"(a) If the court determines that an eligible offender is an addict and is likely to be rehabilitated through treatment, it shall commit him to the custody of the Attorney General for treatment under this chapter. Such commitment shall be for an indeterminate period of time not to exceed ten years, but in no event shall it exceed the maximum sentence that could otherwise have been imposed.

"(b) If the court determines that an eligible offender is not an addict, or is an addict not likely to be rehabilitated through treatment, it shall impose such other sentence as may be authorized or required by law.

"§ 4254. Conditional Release

"An offender committed under section 4253(a) may not be conditionally released until he has been treated for six months in an institution maintained or approved by the Attorney General for treatment. The Attorney General may then or at any time thereafter report to the Board of Parole whether the offender should be conditionally released under supervision. After receipt of the Attorney General's report, and certification from the Surgeon General of the Public Health Service that the offender has made sufficient progress to warrant his conditional release under supervision, the Board may in its discretion order such a release. In determining suitability for release, the Board may make any investigation it deems necessary. If the Board does not conditionally release the offender, or if a conditional release is revoked, the Board may thereafter grant a release on receipt of a further report from the Attorney General.

"§ 4255. Supervision in the Community

"An offender who has been conditionally released shall be under the jurisdiction of the Board as if on parole under the established rules of the Board and shall remain, while conditionally released, in the legal custody of the Attorney General. The Attorney General may contract with any appropriate public or private agency or any person for supervisory aftercare of a conditionally released offender. Upon receiving information that such an offender has violated his conditional release, the Board, or a member thereof, may issue and cause to be executed a warrant for his apprehension and return to custody. Upon return to custody, the offender shall be given an opportunity to appear before the Board, a member thereof, or an examiner designated by the Board, after which the Board may revoke the order of conditional release."

TITLE III—SENTENCING AFTER CONVICTION FOR VIOLATION OF LAW RELATING TO NARCOTIC DRUGS OR MARIHUANA

SEC. 301. Section 7 of the joint resolution of August 25, 1958 (72 Stat. 845) is amended to read as follows:

"SEC. 7. This Act does not apply to any offense for which a mandatory penalty is provided; except that section 4209 of title 18, as amended, shall apply to any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended."

SEC. 202. Section 4209 of title 18, United States Code, is amended by (1) inserting immediately before the first sentence thereof "(a)" and (2) adding at the end thereof the following new subsections:

"(b) A defendant described in subsection (a) of this section who is convicted of a violation of any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended, shall, if the court is considering sentencing him to the custody of the Attorney General pursuant to the provisions of the Federal Youth Corrections Act, be committed to the custody of the Attorney General for observation and study in accordance with the provisions of section 5010(e) of this title. Before sentencing such a defendant to the custody of the Attorney General for treatment and supervision pursuant to the Federal Youth Corrections Act, the court must affirmatively find, in writing, that there is reasonable ground to believe that the defendant will benefit from the treatment provided thereunder.

"(c) Section 5010(a) of this title shall not be applicable to a defendant described in subsection (a) of this section who is convicted of a violation of any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended."

SEC. 303. Section 7237(d) of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(d) NO SUSPENSION OF SENTENCE; NO PROBATION; ETC.—Upon conviction—

"(1) of any offense the penalty for which is provided in subsection (b) of this section, subsection (c), (h), or (i) of section 2 of the Narcotic Drugs Import and Export Act, as amended, or such Act of July 11, 1941, as amended, or

"(2) of any offense the penalty for which is provided in subsection (a) of this section, if it is the offender's second or subsequent offense,

the imposition or execution of sentence shall not be suspended, probation shall not be granted, and in the case of a violation of a law relating to narcotic drugs, section 4202 of title 18, United States Code, and the Act of July 15, 1932 (47 Stat. 696; D.C. Code 24–201 and following), as amended, shall not apply."

SEC. 304. The Board of Parole is hereby directed to review the sentence of any prisoner who, before the enactment of this Act, was made ineligible for parole by section 7237(d) of the Internal Revenue Code of 1954, as amended, and (1) who was convicted of a violation of a law relating to marihuana or (2) who was convicted of a violation of a law relating to narcotic drugs and had not attained his 26th birthday prior to such conviction. After conducting such review the Board of Parole may authorize the release of such prisoner on parole pursuant to section 4202 of title 18, United States Code. If the Board of Parole finds that there are reasonable grounds to believe that such prisoner may benefit from the treatment provided under the Federal Youth Corrections Act (18 U.S.C., ch. 402), it may place such prisoner in the custody of the Youth Corrections Division of the Board of Parole for treatment and supervision pursuant to the provisions of the Federal Youth Corrections Act. Action taken by the Board of Parole under this section shall not cause any prisoner to serve a longer term than would be served under his original sentence.

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. Section 341 of the Public Health Service Act, as amended (58 Stat. 698, 68 Stat. 80, 70 Stat. 622; 42 U.S.C. 257) is amended to read as follows:

"SEC. 341. (a) The Surgeon General is authorized to provide for the confinement, care, protection, treatment, and discipline of persons addicted to the use of habit-forming narcotic drugs who are civilly committed to treatment or convicted of offenses against the United States and sentenced to treatment under the Narcotic Addict Rehabilitation Act of 1965, addicts who are committed to the custody of the Attorney General pursuant to the provisions of the Federal Youth Corrections Act, addicts who voluntarily submit themselves for treatment, and addicts convicted of offenses against the United States and who are not sentenced to treatment under the Narcotic Addict Rehabilitation Act of 1965, including persons convicted by general courts-martial and consular courts. Such care and treatment shall be provided at hospitals of the service especially equipped for the accommodation of such patients or elsewhere where authorized under other provisions of law, and shall be designed to rehabilitate such persons, to restore them to health, and, where necessary, to train them to be self-supporting and self-reliant, but nothing in this section or in this part shall be construed to limit the authority of the Surgeon General under other provisions of law to provide for the conditional release of patients and aftercare under supervision.

"(b) Upon the admittance to, and departure from, a hospital of the Service of a person who voluntarily submitted himself for treatment pursuant to the provisions of this section, and who at the time of his admittance to such hospital was a resident of the District of Columbia, the Surgeon General shall furnish to the Commissioners of the District of Columbia or their designated agent, the name, address, and such other pertinent information as may be useful in the rehabilitation to society of such person."

SEC. 402. The Surgeon General and the Attorney General are authorized to give representatives of States and local subdivisions thereof the benefit of their experience in the care, treatment, and rehabilitation of narcotic addicts so that each State may be encouraged to provide adequate facilities and personnel for the care and treatment of narcotic addicts in its jurisdiction.

SEC. 403. The table of contents to "PART III.—PRISONS AND PRISONERS" of title 18, United States Code, is amended by inserting after

"313. Mental defectives ..... 4241"

a new chapter reference as follows:

"314. Narcotic addicts ..... 4251".

SEC. 404. If any provision of this Act or the application thereof to any person or circumstance is held invalid, the remainder of the Act and the application of such provision to other persons not similarly situated or to other circumstances shall not be affected thereby.

SEC. 405. Title I of this Act shall take effect three months after the date of its enactment and shall apply to any case pending in a district court of the United States in which an appearance has not been made prior to such effective date. Titles II and III of this Act shall take effect on the date of its enactment and shall apply to any case pending in any court of the United States in which sentence has not yet been imposed as of the date of enactment.

SEC. 406. There are authorized to be appropriated such sums as are necessary to carry out the provisions of this Act.

[H.R. 8880, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed therennder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(1) the violation involved the sale of narcotics by such person so charged to another, with knowledge that the person to whom the sale was made intended to dispose of such narcotics by resale;

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence

following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of sectiou 2, the Surgeon General shall cause such person to be examined for the purpose of determiniug whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmissiou of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findiugs contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally npon such person.

(b) In conducting such hearing, the court shall receive and consider all relevaut evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from auy one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed iu accordance with the provisions of this Act .

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraph (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon Geueral which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using snch drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal

to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 8884, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congres assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraphs (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 8888, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs," "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict' means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any

person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraphs (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any nar-

cotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending on any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 8892, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraph (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 8896, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examina-

tion to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraphs (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 8900, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled. That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraphs (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 8904, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraphs (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 8908, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of American in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to n mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(1) the violation involved the sale of narcotics by such person so charged to another, with knowledge that the person to whom the sale was made intended to dispose of such narcotics by resale;

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the finding contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic

addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six month. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or unresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraph (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General shall certify that fact to the committing court and the court Act has successfully completed his probationary aftercare treatment program. the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appro-

priate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 8912, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) The person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraphs (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any

criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 9002, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the perod beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be

made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraphs (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

Mr. ASHMORE. Mr. Chairman, we will be delighted to hear you at this time.

STATEMENT OF HON. EMANUEL CELLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. CELLER. Mr. Chairman and members of the committee, I do not know whether today's proceedings might be termed a withdrawal from the activities last week, using "withdrawal" advisedly.

I am pleased to be here this morning. I am here today on behalf of an idea. This idea is a simple one. It is that drug addiction is a medical problem. This may not sound very revolutionary, but up to now the Congress of the United States, judging by the laws it has passed, has viewed it as a revenue problem and a criminal problem, but not as a question involving the health of our citizens. The brief I am propounding today is simply that there can be no real solution to the problem of drug abuse in this country unless Federal efforts to solve it include a medical approach. I am not calling for the elimination of enforcement efforts. We have a need for them to combat the illegal traffic in drugs. However, high criminal sanctions have not reduced the number of addicts among us. All they have done is increase the addict population of our prisons.

Many of us in the past have called for Congress to recognize that the drug addiction problem in this country has its medical side and to take action based on that premise. The White House Conference on Narcotic and Drug Abuse has documented this contention. The Federal Bureau of Narcotics in testimony before both Houses of Congress has indicated that the medical aspects of the narcotics abuse problem should not be ignored. The time has come to act. An ounce of action is worth a pound of preaching. Congress must take action which will result in addicts being given medical treatment for their addiction. In H.R. 9051, one of the bills before this committee, I have proposed a comprehensive program which I believe is the action Congress should take.

Moving to consideration of my proposal, H.R. 9051, I wish to note, first of all, that it is an omnibus bill. I firmly believe that a successful solution to the drug problem can be achieved only by a comprehensive, across-the-board approach. A piecemeal effort would be

a waste of time, money, and energy. Enacting a civil commitment bill is important. However, civil commitment alone is not enough. You cannot cure an addict of his physical hunger and return him to an environment which engendered his addiction in the first place without helping him to cope with that environment. But more important, you cannot wait until an addict has committed a Federal narcotics crime to try to help him. You must strike at the causes of addiction before addiction generates crime.

I have proposed action on a number of fronts. I should now like to explain the various parts of my proposal.

The first section of the bill creates a civil commitment procedure at the Federal level. A few States, such as New York and California, have enacted civil commitment procedures for use by addicts who have violated State laws. The program in H.R. 9051 has certain similarities to the New York State law. The committee might profit from an examination of the operation of these laws at the State level.

The procedure comes into play when a person is charged with committing a Federal narcotics crime. At that time he is informed of the civil commitment procedure and given an opportunity to elect to take advantage of it. If he decides to elect civil commitment, he is put into the custody of the Surgeon General who has 10 days to determine whether that person is a narcotics addict. If it turns out that the accused is not an addict—and he has a right to be heard on the question—the proceedings against him with respect to the criminal charge are resumed.

If the court, however, determines that the person charged is an addict, it has the discretion to commit him civilly to the custody of the Surgeon General for care, treatment, and rehabiliation.

When the addict is committed to the custody of the Surgeon General, he may be treated for a period of up to 36 months. If the commitment lasts that long, the addict is returned to the court at the end of the period. The addict may be returned sooner if he has been cured of the habit or if his addiction cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment. When the addict, or, I should say, former addict is returned to the court, the court may order up to 2 years of probationary aftercare, also under the supervision of the Surgeon General. Upon successful completion of this probationary period, the original criminal charges are dismissed.

If the addict turns out to be untreatable, he is returned to the committing court and prosecution of the criminal charges, which were initially instituted against him and were held in abeyance during the civil commitment, is resumed. Any time spent in civil commitment must be credited against any sentence imposed as a result of a conviction under that criminal charge.

That in essence is the way the civil commitment procedure would work: treatment instead of punishment; help instead of retribution; cure instead of revenge. The major question that arises is who may use the procedure; which persons may avail themselves of civil commitment. This question is of great importance, for it is worse than useless to have the Federal Government establish a mechanism which no one can use. Now, and in the past, civil commitment proposals

have been introduced whose benefits have been chimerical. This was due to the many exclusionary rules denying access to the procedure.

In my bill there are just two conditions that must be met in order to be eligible for civil commitment: (1) The addict must be charged with a Federal narcotics crime, as was mentioned before, and (2) the crime charged must be other than selling narcotics for the purposes of resale. I do not wish to help those who are in the business of narcotics. They are vultures and they must be punished with all severity.

The first condition offers civil commitment to those charged with a narcotics crime because it is these people who tend to be addicts. Moreover, it is likely that in such situations the reason behind the violation of the Federal statute is the drug habit of the accused.

The second condition is the only real limitation on who may use civil commitment. As mentioned earlier, our approach is a medical one. Therefore, unless there is a major Federal interest that will be thwarted by allowing addicts charged with a narcotics crime to be treated for their addiction rather than punished, the opportunity for electing civil commitment should be available to those who need it. The one situation where I believe there is an overriding Federal interest is where the addict is a participant in the wholesale level drug traffic. There must be no letup in the efforts to destroy the illicit commerce in narcotics. Consequently, under my bill an addict charged with selling narcotics for resale is prevented from using the civil commitment procedure.

Other reasons found in other bills for excluding addicts from electing civil commitments are inconsistent with the basic premise of the proposal. If an addict is a sick person, the fact that he has committed a crime in the past and has paid his debt to society is irrelevant to the question of whether he should be treated for his illness. To do otherwise is to create two classes, only one of which will be favored with treatment. This would be completely inconsistent with the philosophy of a medical approach which does not concern itself with questions of whether a person who is ill is deserving of treatment.

Furthermore, access to civil commitment should not be denied out of hand because of past failures to achieve cure. Drug addiction is known to be a disease where relapses are common. Whether any particular addict will benefit by civil commitment is a judgment that can be made by the judge who is sitting when the case arises. His hands should not be tied by Congress. That is why my bill gives the judge discretion to allow a person accused to receive a civil commitment.

All these exclusionary devices are based on the fear that somehow civil commitment will be used as a means of escaping punishment for some other crime. Each individual case must be scrutinized to determine whether civil commitment will be efficacious. I submit that it should not be the Congress who, at long distance, makes such determinations. In the absence of the facts of individual cases, these decisions can only be arbitrary. The judge is on the scene and has the facts necessary for an informal judgment.

In order to carry out his mandate, H.R. 9051 authorizes the Surgeon General to contract with the States for the use of facilities for

civil commitment and programs of treatment and aftercare. A later section of the bill provides for Federal assistance to the States to aid them in creating these facilities and aftercare programs.

The next part of my bill deals with sentencing provisions. Since the Narcotic Control Act of 1956, harsh penalties have been imposed on Federal narcotics offenders. They have been imposed on high and low alike—the international trafficker and the misguided soul who was caught illegally selling drugs to support his habit. While other criminals were able to get suspended sentences, probation, and parole, addicts were not. Judges found themselves without any discretion in these cases and the net result has been an increase in the addict population of Federal prisons. With respect to these drug addicts, no purpose is served by denying them the hope for release other convicted persons have. The psychological redemption of an addict is difficult enough without singling him out for more stringent treatment than that imposed on common criminals; such as the arsonist. Consequently, this part of H.R. 9051 eliminates mandatory minimum sentences in a number of Federal laws dealing with narcotics and marihuana. It also eliminates the prohibition against granting probation, suspended sentences, and parole in these cases. Moreover, the applicability of the Federal Youth Corrections Act is extended to cover situations where there have been convictions under narcotics law. By these adjustments we will rearm our administrators of justice with the full arsenal of sanctions; such as suspension of sentence, probation, and parole. This is a step fundamental to the success of any rehabilitation program. Returning the quality of mercy to our narcotics laws is a sine qua non to the restoration of hope to those misguided, helpless souls afflicted with this disease.

Proper treatment of Federal prisoners who are narcotic addicts is the concern of the next part of my bill. In keeping with the philosophy of treatment and rehabilitation of drug abusers, the Director of the Bureau of Prisons is given authority to arrange for the use of State facilities for the treatment of addicts. The Attorney General may place addicts in these facilities, as may a sentencing judge. An addict, being a diseased person, should be offered a cure whether in or out of prison. There is no limitation as to which Federal prisoners may be treated for addiction. The type of crime committed by an addict should make no difference in the medical treatment he should receive. Upon cure of his addiction he would complete his sentence, with time spent taking the cure credited against his sentence. If the prisoner becomes eligible for parole, the bill gives the Board of Parole authority to place the parolee under the custody of an appropriate aftercare agency.

This part of the bill would also encourage better care for prisoners with mental and physical defects.

The fourth and fifth parts of my bill establish a program of Federal grants to the States to assist them in the creation of facilities and programs to be used in the battle against drug addiction. These features I consider to be the keystone of my comprehensive program. There is an illicit traffic in drugs because there is a market for them. The market continues to flourish regardless of how harsh criminal

penalties are. That is because there are addicts to be supplied. And addicts breed other addicts. If we can cure an addict, it is the same thing as isolating and curing a carrier of a communicable disease. The time to effect a cure is before addicts break the law. Congress should give the States a helping hand in fighting their addiction problem. As the number of addicts diminishes, so will the illegal international traffic in drugs which is the Federal Government's primary concern.

I have made proposals for helping the States combat drug addiction for some time now. In 1961, I proposed a plan which at that time contained a unique feature. In addition to help in building facilities, the States would be assisted in establishing programs of posthospital treatment and rehabilitation. This, I believed, was the only way to truly combat addiction. By working on the psychological causes of the addict's habit, the tragic circle of physical cure and relapse could be broken. I still hold this belief. I am happy to see that others have adopted this two-pronged approach in their proposals.

Civil commitment, gentlemen, is not easy. It needs regimented therapy, training, education, skilled and understanding physicians, psychiatrists, teachers, social workers, probation and parole officers. Otherwise, civil commitment is a mere euphemism for punishment.

The proposals in my bill regarding facilities and programs of care, treatment, and rehabilitation contain many administrative provisions similar to those used in the Hill-Burton program. The mechanisms used in the proposal in 1961 are less complex. I suggest that the committee examine both mechanisms and ask the Department of Health, Education, and Welfare which type of administrative machinery would be the most useful in administering a program of this type.

In general, let me say a few words concerning this matter which has occupied my study for a long period of time.

Rehabilitation is the goal to be sought. It is not a simple matter, as I said before. The skills and expertise of many are required. The drug abuser who steals or who sells drugs to finance his habit is still engaged in crime. Whether he can or should be held criminally responsible can only be decided by the courts, case by case. No one can say that every confirmed drug abuser is so induced by his habit that he is not accountable for his acts under criminal law. If the abuser is to be penalized, he should not be penalized in the spirit of retribution. The modern concept of criminality should apply; namely, that penalities fit the offenders as well as offenses. Penalties should not be such as to prevent rehabilitation. Society indeed must be protected from the offender for a time, but penalties in specific cases should recognize the need for reformation.

This is certain: The deterrent effect of long sentences is vigorously challenged. The threat of long sentences may deter nonusing traffickers, but long sentences do not necessarily deter the drug abuser. Persistence of narcotics abuse despite severe penalties for possession of narcotics is ample evidence that addicts will risk a long sentence for the drug. The pain of withdrawal is too great to withstand.

Unfortunately, gentlemen, existing information on drug abuse is pitifully inadequate. No one really knows how many drug addicts there are in the United States. The number is estimated between

45,000 and 100,000. Under my bill there is also set up an advisory committee on drug abuse which is to make a comprehensive study in width and depth with reference to this vexatious problem of drugs.

I should like to call your attention to some interesting paragraphs to be found in the President's Advisory Commission on Narcotic and Drug Abuse, page 56. Speaking of the medical use of narcotic drugs, this Advisory Commission report states:

> Since the passage of the Harrison Act in 1914, the Federal narcotics laws have expressly permitted a physician to prescribe narcotic drugs for a patient in the course of "professional practice only" and for "legitimate medical uses" and "legitimate medical purposes." Under this statutory language there is no doubt that a physician may prescribe narcotic drugs for a patient suffering acute pain or from a painful and incurable disease. But a controversy has existed for 50 years over the extent to which narcotic drugs may be administered to an addict solely because he is an addict.
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> During the first 10 years following enactment of the Harrison Act, the Supreme Court affirmed several convictions under the act involving the indiscriminate prescribing of narcotic drugs for addicts. In 1925, however, in *Linder* v. *United States*, 268 U.S. 5, the Court indicated that the dispensing of narcotic drugs by a physician for the purpose of relieving conditions incident to addiction was not in every instance a violation of the act. The case concerned a doctor who had given one tablet of morphine and three tablets of cocaine to an addict. The Harrison Act, said the Court, "says nothing of 'addicts' and does not undertake to prescribe methods for their medical treatment. They are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purpose solely because he has dispensed to one of them, in the ordinary course and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to addiction."

End of quote with reference to the extract from the decision. Then the report goes on to say significantly:

> The regulations of the Bureau of Narcotics, however, do not seem to be in accord with that language. The current regulations state: "An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of the [Harrison] Act; and the person filling such an order, as well as the person issuing it, may be charged with violation of the law."

Then the President's Commission went on to say:

> The practicing physician has thus been confused as to when he may prescribe narcotic drugs for an addict. Out of a fear of prosecution many physicians refuse to use narcotics in the treatment of addicts except occasionally in a withdrawal regimen lasting no longer than a few weeks. In most instances they shun addicts as patients.
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> * * * * * * *
>
> *The Commission recommends that Federal regulations be amended to reflect the general principle that the definition of legitimate medical use of narcotic drugs and legitimate medical treatment of a narcotic addict are primarily to be determined by the medical profession.*

I hope the committee will take some time out to look into the observations made by the President's Advisory Commission on Narcotic and Drug Abuse.

In Great Britain, the physician can administer the drug as the physician deems best in his medical judgment. He is not hampered by archaic or punitive statutes. The British physician can prescribe narcotics as a part of a process of gradual withdrawal. He can pre-

scribe the drug when the addict cannot safely be detoxified because of the severity of the resulting symptoms or when the patient is considered to be capable of leading a useful life only when a minimum dose is regularly administered. He cannot prescribe the drug solely to gratify addiction, and every effort must be made to cure the addict. There are no maintenance clinics in Great Britain. Each case is handled by the individual practitioner. Great Britain has few drug addicts. In 1962 the United Kingdom reported to the United Nations that it had only 532 known drug addicts. This is indeed a low incidence. Perhaps the fact that the physician is trusted there, as he apparently and unfortunately is not trusted in the United States, may be one of the reasons for the low incidence.

That completes the description of H.R. 9051. I do not claim my bill is the ultimate answer to the problem of drug addiction and abuse in the United States. But it is a start, and, I believe, a good start. What I think is most important about the program is the principle on which it is based—recognition of the fact that drug addiction is a medical problem; recognition that we are dealing with sick people. If this committee and the Congress incorporate this idea into the Federal Government's approach to the question of drug abuse, it will be a significant step forward in the battle against the terrible ravages of addiction.

I also wish to comment about the administration's bill, H.R. 9167, which I also introduced. I have certain opinions and positions regarding the questions under consideration today. However, I do not claim to be the font of all wisdom on this matter. There are other approaches to these problems, some of which are found in H.R. 9167. I am sure the administration bill was drafted after much careful consideration by representatives from a number of agencies and departments. Reasonable men may differ. Therefore, their collective judgments may be different from mine. What I hope to accomplish is to have the fullest consideration by the committee of all reasonable alternatives. Thus, through the cooperation of all concerned parties an effective program can be created. I must emphasize again, however, that I believe the program must be comprehensive if it is to be effective in reducing drug addiction in this country. Consequently, it must go further than the administration's proposal and assist the States in combating addiction medically before it engenders Federal crimes. This added feature is found only in my bill, H.R. 9051.

I want to say, gentlemen, there were some four proposals embodied in four suggested bills. The bills were to go to various committees. I took it upon myself to draft the bill which I have discussed so as to get the bill before the Judiciary Committee. It embodies most of the features of all these various and sundry bills.

I should like to place in the record a comparison between the administration bill H.R. 9167, and my bill, H.R. 9051.

Thank you very much, Mr. Chairman.

(The document follows:)

COMPARISON OF NARCOTICS LEGISLATION

D. J. BILL, H.R. 9167 (CELLER)	H.R. 9051 (CELLER)
I. Preconviction proceedings	
1. Persons included	
Persons charged with a violation of Federal law.	Person charged with a violation of a Federal *narcotic* law.
2. Time for election	
5 days.	10 days.
3. Incligibles	
(a) Person charged with crime of violence.	(a) Not applicable in view of 1.
(b) Persons charged with sale unless sale is to support their own addiction.	(b) Sale for resale.
(c) Person against whom is pending uncompleted felony charge, probation, parole, or unserved sentence, unless appropriate authority consents to commitment.	(c) No.
(d) Person convicted of felony two or more times.	(d) No.
(e) Person civilly committed by Federal or state two or more times.	(e) No.
4. Precommitment exam	
60 days.	10 days.
5. Criteria for commitment	
Must be an addict and be likely to be rehabilitated.	Must be an addict.
6. Committing authority	
U.S. district court.	"Committing magistrate"—would include a United States Commissioner.
7. Credit against sentence	
For time spent in institutional custody.	Credit for time spent in any custody—would include aftercare.
8. Termination of commitment	
(a) Successful completion of treatment program—charge dropped.	(a) Successful completion of program and aftercare—charge dropped.
(b) Cannot be further treated as a medical problem—proceeding *must* be resumed.	(b) Cannot be further treated as a medical problem because of incorrigibility or unresponsiveness—proceeding on charge *may* be resumed.
(c) Expiration of 24 months and no sufficient progress warranting release on aftercare—treatment *may* be continued or proceeding on charge *may* be resumed.	(c) No.
(d) Expiration of 36 months and no successful completion of treatment—proceeding *must* be resumed.	(d) Expiration of 36 months—placed on aftercare for maximum of 24 months.
(e) Return to narcotics during aftercare—treatment *may* be continued or proceeding on charge *may* be resumed.	(e) Same concept.
	(f) Effectively removed from use of narcotics—*placed on aftercare.*
9. Aftercare	
Specifically provides for tests, examinations, etc.	No.

D. J. BILL, H.R. 9167 (CELLER)	H.R. 9051 (CELLER)
10. Effect of commitment	
Not to be deemed a conviction but fact of addiction may be used to attack credibiiity as a witness.	Not to be deemed a conviction.
11. Aftercare facilities	
Any public or private agency or person.	Any state.
12. Effective date	
Three months after enactment.	To any case pending in court as a result of an arrest after December 31, 1965.
13. Hearing on commitment	
None.	Hearing if contested.
II. Postconviction treatment	
1. Methods of commitment	
(a) Authorizes judge to sentence persons included in the bill to treatment.	(a) Authorizes Director of Bureau of Prisons to contract with states for, and to use, their treatment faciiities. (b) Authorizes Attorney General to use facilities described in (a) for treatment of prisoners. (c) Authorizes court to order Attorney General to confine person in treatment facility.
2. Persons included	
An addict convicted of a Federal offense, unless ineligible, who is likely to be rehabilitated.	An addict, *or any person suffering from a mental or physical condition,* who is likely to be helped by treatment or rehabiiitation; irrespective of offense charged.
3. Duration of commitment	
Minimum of six months in institutional custody, then on aftercare at any time.	Until treatment is no longer needed or desired, then person may be returned to a penal institution. Makes no provision of other dispositon of prisoner.
4. Aftercare	
At any time after six months institutional treatment, in discretion of Parole Board on basis of Surgeon General's and Attorney General's reports.	At any time parole is authorized.
III. Penalties	
1. Federal Youth Corrections Act	
(a) Permits 22–25-year-old offender convicted of a narcotic offense requiring a manatory penalty to be sentenced under the Federal Youth Corrections Act by amending the joint resolution which permits such sentencing for other 22–25-year-olds.	(a) Accompliishes same result by amending 18 U.S.C. 4209 (codification of joint resolution).
(b) Not covered, since it can be done under present law.	(b) Amends the Federal Youth Corrections Act to permit sentencing under it of otherwise eligible youths convicted of narcotic offenses requiring mandatory penalties, subject to 26 U.S.C. 7237(d).

D. J. BILL, H.R. 9167 (CELLER)	H.R. 9051 (CELLER)
2. Parole	
Makes parole available to all marihuana offenders and to 22–25-year-old narcotic offenders sentenced under the Federal Youth Corrections Act.	Makes parole available to marihuana *and narcotic* offenders.
3. Probation or suspended sentence	
None.	Makes probation or suspended sentence available to only marihuana offenders now ineligible therefor—persons over 18 transferring to persons under 18, subsequent offenders, and smugglers—and to all narcotics offenders now ineligible therefor except (1) persons over 18 transferring to persons under 18 and (2) conspirators to such sales.
4. Implementation procedures	
Requires Board of Parole to review sentences of persons now eligible for sentencing under the Federal Youth Corrections Act or eligible for parole.	No.
5. Minimum mandatory penalties	
Not covered.	Eliminates minimum mandatory penalties for all marihuana offenses and all narcotics offenses except those narcotics offenses in 3 (1) and (2) above, and those for importing narcotics, transfer of heroin to person under 18 by person over 18, and possession of narcotics on vessels. Lowers minimum mandatory penalty for offenses in 3 (1) and (2) above from 10 to 5 years.
IV. Grants-in-aid	
1. Grants to States for construction of facilities	
None.	$15,000,000 authorized to be appropriated for each year—1965, 1966, and 1967—for construction of treatment and rehabilitation facilities for drug abusers.
2. Grants to States for services	
None.	$7,500,000 authorized to be appropriated for each year—1965, 1966, and 1967—for establishing treatment and rehabilitation services for drug abusers.

Mr. ASHMORE. Thank you, Mr. Chairman.

I believe the administration bill has a similar civil commitment provision to your bill. Is that correct?

Mr. CELLER. That is true.

Mr. ASHMORE. Is the main distinction between your bill and the administration bill the provision in your bill which provides funds to assist the States?

Mr. CELLER. That is correct.

Mr. ASHMORE. Would you give us some of the details of your bill with reference to these provisions?

Mr. CELLER. With respect to facilities, provision is made to authorize an appropriation initially of $15 million to aid the States. The Department of Health, Education, and Welfare is to administer the program and parcel out the funds. The Department establishes standards for the facilities and publishes them in regulations. The States who wish to avail themselves of the program designate a State agency which then formulates a State plan. Upon submission to HEW, that Department passes on the plan to assure that it meets the standards stated in the regulations. Grants for facilities are made to those States whose plans are approved.

In addition, there is a $7.5 million program for the development of programs at the State level for care, treatment, and rehabilitation of drug addicts. The mechanics of administration of the grants are similar to those used in the facilities program. In addition to State activity assisted by these grants, private organizations would be encouraged to devote energies and moneys for the rehabilitation of addicts. Research programs would be planned and developed. An advisory committee is to be set up, compensation of the members of which would be at the rate of up to $75 a day for work performed. They would assist the Secretary of Health, Education, and Welfare in administering these programs and encouraging research and development in this area. They would work with the States and work, also, with the Department of Health, Education, and Welfare. That is a bird's-eye view of it, Mr. Chairman.

Mr. ASHMORE. The research program you recommend or propose would be incorporated in State institutions, or would they be entirely in the hands of the Federal Government?

Mr. CELLER. They would be in both.

Mr. ASHMORE. The administration bill has no provision at all with reference to research.

Mr. CELLER. No, it has not.

Mr. ASHMORE. What would the administration bill do with the addicts when they are committed? Would they go on to Federal institutions, or would new institutions be constructed?

Mr. CELLER. You are talking about provisions in the administration bill. I want to do justice to it. Mr. Katzenbach will be the next witness and can probably answer the question more fully. However, I think you will find in section 401 of H.R. 9167 that "the Surgeon General is authorized to provide for the confinements, care, protection, treatment, and discipline of persons addicted to the use of habit-forming narcotic drugs who are civilly committed to treatment or convicted of offenses against the United States and sentenced to treatment under the Narcotics Addiction Rehabilitation Act," and so forth.

It is very comprehensively worked out in that section, pages 18 and 19 of the administration bill.

Mr. ASHMORE. I was particularly interested in the aftercare program, Mr. Chairman. When an addict has been committed to an institution and then he is released, what care is given to him?

Mr. CELLER. There is a probationary period provided for upward to 2 years.

Mr. ASHMORE. When he leaves the institution would he be placed under the Attorney General or the district attorney's office and probation and parole officer?

Mr. CELLER. He would be under, in my bill, the Surgeon General.

Mr. ASHMORE. Is the Surgeon General equipped for such probation and supervision?

Mr. CELLER. I do not suppose he is equipped now, but appropriations would have to be made to give him the proper equipment for that purpose.

Mr. ASHMORE. I am wondering, would it be more economical for him to go under the care and probation and supervision of the Department of Justice where they have probation officers and can provide for this program under the present probation system?

Mr. CELLER. There would be liaison with the Department of Justice, of course. The parole board and the probationary officers in the Department of Justice would be used in cooperation with the Surgeon General.

Mr. ASHMORE. What has the medical profession or what has the Surgeon General, if you know, done with reference to psychological treatment of these people after they are released? My knowledge of this problem does not give me much information on what has been done in that regard. Is there any new method or scientific treatment that can now be provided for these people not provided in the past? What is the research on that?

Mr. CELLER. There are quite a number of studies in the offing, and other studies which have been completed. If you are interested in it there is a very entertaining and revealing article in past issues of the New Yorker magazine which indicate that limited quantities of methadone, which is a substitute narcotic, can be used in reduced dosages during the withdrawal period. I do not know how efficacious that is, whether it is medically proper, but considerable excitement has been developed on that score.

I do not have sufficient expertise to be able to give you an answer as to what the psychological effects would be of that particular substitute drug or any other drug or any other treatment. I would not be able to give you the proper information I fear.

Mr. ASHMORE. All right.

Mr. Gilbert?

Mr. GILBERT. Thank you, Mr. Chairman.

Firstly, may I compliment my distinguished chairman of the Judiciary Committee for his excellent presentation this morning.

I think this problem is very serious and of great concern to me for many, many years. I represent a community which unfortunately probably has quite a high percentage of use of narcotics and also probably a great deal of trafficking in narcotics in the community.

I think the bills of the chairman and the administration have certainly gone a long way toward solving some of the problems.

The thing that has always disturbed me with an attempt to control the narcotic problem is not something that I find that any bill has covered. It is simply this: Provide for commitment. You provide for aftercare treatment but the narcotic user returns to his old environment and he is now subjected to all the same pressures he was previously or prior to his commitment.

Is there anything within your bill or the administration's bill, or any thinking that you know of on this subject?

Mr. CELLER. Naturally you did not have time to read the bill. As you read the bill you will find that we provide for the States to assume a considerable burden in this matter. They are to set up pilot plants for research and development and provide facilities, clinics, and hospitalization so that these addicts can be cured of their malady, their disease, before they attempt any crimes.

I feel that the bill provides a very comprehensive basis for programs to meet these needs. These purposes become clear when one reads it carefully, it covers about seven or eight pages.

Mr. GILBERT. This is what I specifically have reference to, Mr. Chairman——

Mr. CELLER. May I say this: The Federal Government cannot take jurisdiction until a Federal crime is committed.

Mr. GILBERT. I am not primarily interested in that, Mr. Chairman. Very frankly whether it is the Federal Government or the State. What I am interested in basically is trying to eliminate the problems. We have in your bill and the administration bill provisions for commitment. We have provisions for aftercare. Assuming that you have an individual who is applying for civil commitment after the commission of a crime and the court in its wisdom determines that this particular defendant should subsequently receive commitment, he receives his treatment at some institution that will subsequently be provided for.

He now has served his allotted time at some facility under civil commitment and he is released from that particular institution and he is released as a free individual except that he may have some conditions placed upon that such as parole where he has to return to some local hospital or some institution that would be provided for his care.

Nevertheless he is not institutionalized. He returns home to the same environment, the same area that no doubt created this desire for drug addiction.

But what I am interested in is that something be done with respect to this individual when he returns home and the mere supervision of him by asking that he return voluntarily for treatment somewhere, I am afraid, is not going to cure his problem. I am afraid that all the money that is going to be spent may go down the drain.

Mr. CELLER. You assume that the treatment, aftercare treatment, will come to an end and the addict will still have a proclivity to resume his habits when he gets into his old environment; is that correct?

Mr. GILBERT. That is correct.

Mr. CELLER. We are endeavoring to prevent that. The latter part of the bill provides for Federal aid to the States to develop the most wide and deep care, treatment, and rehabilitation. These programs are to be used to fight addiction before it results in causing crime. Of course, they will also be used for those addicts who have undergone civil commitment.

I do not say it is going to be successful in all cases but I think there will be such a measureable degree of success, if this is put into effect, as to make this bill worthwhile. There is no perfect answer, sir.

Mr. GILBERT. I understand that, Mr. Chairman. Do you envision in your bill or under the programs that have been discussed that there is going to be job training for these people?

Mr. CELLER. Yes, sir.

Mr. GILBERT. These people basically are unemployable, they do not have any skills or any professions. They drift.

Mr. CELLER. The State programs must meet the standards established by the Secretary of Health, Education, and Welfare. These Standards will be spelled out in regulations, and I quote from section 20 of my bill:

> * * * Such regulations shall include, among others, provisions prescribing the kinds of treatment and rehabilitation services for drug abusers for which grants may be made under this act such as, but not limited to, detoxification or other medical treatment, physical therapy, family counseling, psychotherapy, vocational training, help in finding employment, or probation-type supervision.

Mr. GILBERT. I think those provisions certainly would be very helpful in solving this problem, as important possibly as the medical aspect of it is, I think the psychological aspect of the problem is important if not more so.

I presume, listening to you here this morning, Mr. Chairman, you have given some thought to the English system of some sort of treatment of the addict by setting up stations in hospitals for their treatment?

Mr. CELLER. They have no such thing.

Mr. GILBERT. They have none today?

Mr. CELLER. It is all left to the physician.

Mr. GILBERT. That is correct.

Mr. CELLER. They look upon an addict as being in a situation similar to someone with diabetes or heart trouble. The addict is placed in the control of his physican. The physician has a fair degree of responsibility and discretion to provide for the drugs. They have a very low incidence of drug addiction in Great Britain. That may be due to the homogeneity of the population there. There seems to be a different type of feeling toward drug addiction over there than we have in our country. However, an increase in drug addiction has been found there recently, perhaps due to the fact that society is becoming more pluralistic in Great Britain.

I do not know what effect that will have generally on the incidence of drug addiction there.

Mr. GILBERT. I notice here in the report of the President's Advisory Commission on Narcotic Drug Addiction that the Commission recommended that the Federal Government encourage and increase assistance to States and municipalities to develop and strengthen their own treatment programs.

Mr. CELLER. Incidentally, in New York City Mayor Wagner testified, I think, when he was asked the question, he thought there were about 50,000 drug addicts in New York. I think that is a little high but it may be true.

Mr. GILBERT. With all due respect, Mr. Chairman, I think it is a little low.

Mr. CELLER. Some estimates indicate there are about 100,000 throughout the country.

Mr. GILBERT. There are more than in other areas because the intensity in my district is pretty high.

Mr. CELLER. Your district is high.

Mr. GILBERT. I am deeply concerned with the problem.

Mr. ASHMORE. Mr. Chairman, I believe New York State has a law similar in some respects to your bill or similar to the administration's bill; is that correct?

Mr. CELLER. My bill is similar to the New York statute.

Mr. ASHMORE. California also has a similar law, I believe. Are you familiar enough to say what success or how successful you think the New York law has been? Has it reduced addiction any?

Mr. CELLER. I do not think the New York statute has been in effect long enough to be able to adequately gage its success. I think we need a little more time in that regard.

Mr. ASHMORE. You would not be in a position to comment?

Mr. CELLER. No, sir.

Mr. ASHMORE. To compare the New York and California law?

Mr. CELLER. I think it would be well if we had somebody appear from New York State who is connected with that program and testify. It might be very revealing.

Mr. ASHMORE. I presume the Attorney General or Surgeon General would have the figures on those two States.

Mr. GILBERT. I understand, Mr. Chairman, that in a voluntary hospital at Riverside, right off of the Bronx for the care of narcotic addicts that there were indications that it was not used to capacity. I do not know if it is still operating.

Mr. CELLER. I do not know.

Mr. GILBERT. This requires an intensive program of education. With all of the platitudes and wondering what we are going to do, we must get this across to the people so that they understand; as you provide in the bill, that there is not going to be any stigma attached.

Of course, you reach them at the point after they have committed a crime. I think that we should make some provision for those addicts who wish to voluntarily receive treatment, not by going out to Lexington, Ky., but somewhere close by to their homes. We apparently do not always have sufficient facilities available to those people and then when you do have facilities available they do not make use of them.

Again, I want to thank the chairman. I am sorry that I cannot stay here longer and participate in this because there is another subcommittee that I am on at the present time and I hope after spending 2 years on the immigration bill with the Attorney General we are going to see some light.

Mr. CELLER. Do not spend 2 years on this bill.

Mr. GILBERT. I do not think so.

Mr. ASHMORE. Mr. Senner?

Mr. SENNER. I would like to also commend the distinguished chairman of the Judiciary Committee for the fine statement he has made here today. Nothing I can say would add luster to his distinguished career. I am sorry to state that I am not an expert in narcotics, and perhaps I should be glad of that fact.

Looking at your bill and the administration's bill, the point that I have in my mind—and perhaps Mr. Gilbert was trying to make—is do you have any objection to permitting a drug addict in the rehabilitation stage to seek drugs or administration of this vile disease by the private aspect of the treatment as distinguished from the Federal or State?

Do you follow what I am saying?

Mr. CELLER. By a physician, you mean?

Mr. SENNER. Administer drugs to him rather than going through a Federal or State agency.

Mr. CELLER. I think more discretionary power should be given the physician than the physician has now. There ought to be a clarification of the regulations with review of the narcotics. The Bureau of Narcotics regulation is so narrow as to frighten most physicians. You talk to doctors and they have an abhorrence of addict patients. They will not have anything to do with them because of fear of getting entangled with the Federal statute.

Mr. SENNER. Would you have any objection if this committee were to write into your bill provisions that would permit private physicians to treat the drug addict that has gone through the stages of rehabilitation and processed by the Federal and State Government to administer that?

Mr. CELLER. Not at all. I would warn, however, that the committee should get advice and counsel from the American Medical Association as to how that should be done. I think the American Medical Association is on record asking that the very restrictive regulations of the Bureau of Narcotics be revised in the interest of giving the physician more discretion in the prescription of drugs which they might administer under certain circumstances to drug addicts.

Mr. SENNER. Is it not true that if we take this step in narcotics we have taken a giant step forward in combating that?

Mr. CELLER. By all means, of course, this is not the only step we can take. For instance, we could improve our enforcement efforts. In some respects our facilities for the detection of smuggling of narcotics is woefully lacking. There are hardly any agents in the various parts of Europe where they grow the opium poppy and in those countries in the Middle East, like Turkey and Iraq and Lebanon, where they manufacture these drugs. You have to have our agents over there. We only have a few of them there. When you consider the vast mileage of border between Mexico and the United States, then you realize the difficulty of policing that situation. A good deal of illegal traffic goes across the Mexican border, the southern part of your State.

You ought to know something about the smuggling of marihuana. It comes from Mexico in very large quantities.

Mr. SENNER. Heroin is also smuggled across the border. The point I am trying to make is that I cannot see why the administration's or your bill does not provide for some provision that would permit the private enterprise field to treat the drug addict and to try to cure him.

Mr. CELLER. My bill does not cover that. Certainly it could. I do not know whether you want to put that in the bill. You might put that in the report and have somebody from the Bureau of Narcotics up here and have them change their regulations.

The difficulty is in the regulations of the Bureau of Narcotics. If you could have those regulations changed it would give more discretionary power to the physician.

Mr. SENNER. Private physician?

Mr. CELLER. Yes, sir.

Mr. SENNER. I appreciate the chairman's comments and statement here today.

Mr. ASHMORE. Mr. Hungate, do you have a question?

Mr. HUNGATE. I wish to join my colleagues in complimenting the chairman on his usual fine job of draftsmanship, I would say, on this bill and on the administration's bill.

Might I inquire if you have an idea of the approximate number of addicts we have in the United States, Mr. Chairman?

Mr. CELLER. I said in my statement that the information generally on drug addiction is very meager. It has been estimated that the number of drug addicts runs from 45,000 to 100,000 in the United States. Mayor Wagner testified that he thought there were about 50,000 in New York City.

You touch one of the soft spots here that has to be hardened. We have not got enough information on this subject. There ought to be some agency to really do the job here, get all the figures, get all that is to be known about drug addiction from every conceivable angle and aspect of it. We need all that before we can attack this problem.

Mr. HUNGATE. Mr. Chairman, from those figures would it not appear that approximately 50 percent of the known narcotic addicts are in New York State?

Mr. CELLER. I do not want to admit that, nor do I want to deny it. I do not know. That was a guess on Mayor Wagner's part. It may be.

Mr. HUNGATE. Thank you, Mr. Chairman.

Mr. ASHMORE. Mr. Grider?

Mr. GRIDER. No questions.

Mr. ASHMORE. Mr. King?

Mr. KING. Mr. Chairman, on behalf of the minority, I want to congratulate you on your statement. I think I know what you are trying to do and I commend you for it. Are you suggesting that we might bring someone down from New York who has had a great deal of experience with this? I assume you mean someone from Mr. Cooley's office and Mr. Hogan's office?

Mr. CELLER. I think it would be well to get somebody from any of our very able district attorney's offices.

Mr. KING. I sent them copies of these bills and asked them if they would be willing to send someone down here, Mr. Chairman. I am glad to see you agree with me on that.

Mr. CELLER. No question. Probably some of the district attorneys up in the other part of the State, too.

Mr. KING. Does your bill cover retailers as well as wholesalers of narcotics?

Mr. CELLER. Yes, sir.

Mr. KING. Let us assume that a judge has sent one of these fellows to an institution for treatment. Then let us assume that he decides he does not want any more treatment and he leaves. May he leave voluntarily? If so, he is then brought back and prosecuted for the crime?

Mr. CELLER. He cannot leave voluntarily. If the court judges that he is an addict, he is placed under surveillance, control, without question.

Mr. KING. Not in a prison however?

Mr. CELLER. Not necessarily in a prison. No.

Mr. KING. You know that most of our hospitals, especially in the State of New York, where we send people awaiting trial, or convicts for treatment of sickness or disease, will always complain they have no facilities for securing these people who are prisoners unless of course it is a penal institution?

Mr. CELLER. That is one of the troubles. We have to widen and expand our facilities. This is a tremendous problem and it is not going to be solved in a day.

Mr. KING. You envision they will have some security in these institutions to keep these fellows under surveillance?

Mr. CELLER. You have to have for the protection of society.

Mr. KING. I realize that. Let us assume, then, that a narcotic addict rejects this treatment program, and comes back for trial. May he not then move to dismiss the indictment against him because there has been a failure to prosecute, or lack of speedy trial?

Mr. CELLER. As I said, the judge has to determine on a case by case basis. If he is incorrigible, if he is intransigent and refuses to take treatment or if he is so far gone that treatment would be unavailing different approaches must be added to that plan.

If in the instances where he is incorrigible or refuses to take treatment, he must stand punishment for the crime he committed.

Mr. KING. Whether he is a first offender or a multiple offender?

Mr. CELLER. It makes no difference.

Mr. KING. Or a youthful offender?

Mr. CELLER. If he refuses to take the cure or refuses to place himself under control and enable the cure to be made effective, he then must face the criminal charge and take the consequences.

Mr. KING. You say send him up to an institution for 36 months. Let us assume he stayed there 2 years and then he says, "I don't want any more of that. I want to go back and be tried." In the meantime the Government's witnesses may have all disappeared.

Mr. CELLER. The criminal charge will always hang over his head until the judge dismisses the case.

Mr. KING. Is it not a good way for him to avoid prosecution in the first instance and let the people's witnesses disappear?

Mr. CELLER. If he is such a faker, those who have surveillance over him to detect his trickery report that to the court.

Mr. KING. What do you think of his motion to dismiss because he did not get a speedy trial?

Mr. CELLER. I do not think that would be a lack of a speedy trial. He would be a diseased person and has to be cured.

Mr. KING. As a diseased person could he make a choice?

Mr. CELLER. In the beginning he does not get this treatment unless he consents to this matter of commitment.

Mr. KING. Has he the mental capacity to consent if he is a drug addict?

Mr. CELLER. There again, the question whether a drug addict is able to consent is a matter of issue that the court must determine at the very initial stages.

Mr. KING. You have provided for that?

Mr. CELLER. Yes, sir. We have provided for that in that the judge has discretion whether to allow civil commitment. All these factors must be resolved in his mind at that time.

Mr. KING. Is there any appeal in the event of abuse of discretion? Let us assume that the judge uses his discretion. May a prosecutor appeal, for example, and claim that the judge has abused his discretion?

Mr. CELLER. You have got me. For the moment I do not remember. I do not think it is in here. I doubt it. I do not think it is in this bill. Forgive me, I do not know all the details of the bill having been through the throes of a voting rights bill last week. I could not do all my chores on this.

Mr. KING. I do not know how you are ever going to get things straightened out in your mind after what you have been through.

Is there a provision in the bill that a judge must determine or find some causal relationship between the man's use of drugs and the crime with which he is charged?

Mr. CELLER. Yes, sir, there is provision in there.

Mr. KING. Can you tell us where that might be? Can your counsel tell us where that might be so we can be sure and cover it?

Mr. CELLER. Counsel tells me on page 4, line 11, of my bill in subsection (c), you will find the determination the judge must make. You might run your eye down that. As for your specific question, I am told it is in the administration's bill and not in my bill.

Mr. KING. In the interest of time, Mr. Chairman——

Mr. CELLER. Perhaps one of the administration men could tell us.

Mr. KING. I am asking the Attorney General, thank you very much. I appreciate your help.

Mr. CELLER. All right.

Mr. GRIDER. Would the gentleman yield for a moment?

Mr. KING. I yield.

Mr. GRIDER. Mr. Chairman, does not this bill of yours apply only to violations of Federal laws relating to narcotics?

Mr. CELLER. That is correct.

Mr. GRIDER. Does that not answer the gentleman's question?

Mr. CELLER. That is correct. The Federal Government would not get jurisdiction unless an addict commits a narcotics crime. But we want him to get help before that happens. That is why we bring in the States. By virtue of giving a subvention we encourage the States to attack the problem of drug addiction.

Mr. GRIDER. This law would not be available to a man charged with murder, for example, who just happened to be an addict, would it?

Mr. CELLER. No, sir. Under H.R. 9051 an eligible individual is one charged with the violation of a Federal penal law relating to narcotics. Under H.R. 9167 civil commitment is denied persons charged with crimes of violence. We would have no jurisdiction over that.

Mr. GRIDER. Let us say murder of the President.

Mr. CELLER. It is hoped that other States will follow the lead of California and New York and if we adopt one of these bills that that would be a banner that other States could follow.

In response to the earlier question of the gentleman from New York, Mr. King, I believe the language he was looking for is found on the administration's bill, on page 6 of H.R. 9167, lines 9 to 12:

• • • If the court determines that the individual is an addict and is likely to be rehabilitated through treatment, the court shall commit him to the custody of the Attorney General for treatment.

Mr. KING. Thank you, Mr. Chairman.

Mr. ASHMORE. Mr. Hutchinson?

Mr. HUTCHINSON. Mr. Chairman, your bill as I understand it contemplates a program of Federal aid to the States for, among other things, building of facilities. These facilities contemplated, would they be quite like the facilities at Lexington and Fort Worth? That is, would they be quite like those facilities and carry on about the same programs those two Federal facilities carry on? I am thinking about State facilities under the program. Would they be doing about the same thing as these two Federal agencies are now doing?

Mr. CELLER. They would be like those at Lexington and there would be deviations therefrom. They would also be sort of halfway houses.

Mr. HUTCHINSON. What are they, Mr. Chairman?

Mr. CELLER. That is where a person who has completed the treatment to rid him of his physical hunger can stay during the next step in his treatment. It is to help him adjust to the outside world again. There are a number of halfway houses in the country, so-called halfway houses. This type of facility would be under the rules and regulations of the Department of Health, Edcation, and Welfare, and the Surgeon General.

Mr. HUTCHINSON. I assume the treatment there at the halfway house would certainly to a degree be psychological and need psychiatrists and people skilled in environmental and mental attitudes, is that right?

Mr. CELLER. I think that is true. This psychological help occurs in the later stages of treatment. In the initial stages they would get the drug also.

Mr. HUTCHINSON. They would get the drug?

Mr. CELLER. They would get the drug during the period of withdrawal.

Mr. HUTCHINSON. Withdrawal?

Mr. CELLER. Yes, sir.

Mr. HUTCHINSON. Would you envision, Mr. Chairman, that such a facility would be set up in every State?

Mr. CELLER. I doubt very much whether there be need for a facility in every State. I do not think so.

Mr. HUTCHINSON. Under the ordinary program of Federal-State, Federal aid to States in these programs, ordinarily all of these programs set up have a certain amount of money available to each State based upon some kind of a formula.

It occurs to me that probably the States which have the most need for such facilities are New York and California. Both of those States already have such facilities.

Mr. CELLER. They have some. I do not know how adequate they are. That is a matter that has to be left to the discretion of those placed in authority under this bill. I would take it that every State certainly would not need these facilities.

Mr. HUTCHINSON. Is it your thinking, Mr. Chairman, that the States are financially unable to provide these facilities without Federal aid and direction?

Mr. CELLER. Some of them may not be. New York probably is able, although it is in rather straitened financial circumstances, as are most States. But drug addiction is a national problem. You must re-

member that we do not manufacture narcotic drugs in the United States. It comes from abroad. There is a tremendous traffic in it. Therefore, the Federal authority has the responsibility for it. Since the States may be victims of this traffic, they have a right to appeal to the Federal Government for aid to prevent the further spread of the addiction and for assistance to help cure those people who are addicted. The Federal Government, having been proven guilty in a certain sense because it has not stopped the flow of these drugs, has a certain responsibility to the States.

Mr. HUTCHINSON. Thank you, Mr. Chairman. That is all.

Mr. ASHMORE. Mr. McClory?

Mr. MCCLORY. Mr. Chairman, I want to compliment you on your fine statement and your continuing espousal of worthy causes. I was interested, following your comments the other day about the representatives from Podunk, Squeedunk, and from the boondocks in the New York State Legislature, that such fine legislation could emanate from that body that you now want to pattern Federal law after New York?

Mr. CELLER. Of course, you must realize that the drafting of some of those good laws was participated in by those from the urban areas, too.

Mr. MCCLORY. Mr. Chairman, I am interested in several aspects of your testimony. For one thing, I would like to know whether you also favor H.R. 9167.

Mr. CELLER. I favor both bills. One goes a little further than H.R. 9167. I offered both of them.

Mr. MCCLORY. You referred rather favorably to the British system, about which I would not go into detail, but with which we all have some familiarity. You are not telling us that that is working and effective and reducing the number of addicts in Britain?

Mr. CELLER. I just read the statement from the President's Advisory Commission and they seem to point to the fact that the British have had a fair degree of success over there with their method.

Mr. MCCLORY. My information is that the number of addicts in Britain is on the increase and not decrease and while that is an interesting and novel system they have, it is not effective either. Perhaps we will get more on that in the course of the hearings.

Mr. CELLER. I did say earlier that the incidence in England has been increasing.

Mr. MCCLORY. Actually a great deal of the illegal narcotics traffic emanates from the allotments of narcotic drugs to the members of the medical profession, is that not right?

Mr. CELLER. I have no knowledge of that.

Mr. MCCLORY. The amount that you are suggesting in the legislation would total $22,500,000; $15 million for facilities and $7,500,000 for services. Do you think that that is adequate?

Mr. CELLER. No. It is only a start.

Mr. MCCLORY. I notice in the State of New York alone, for instance, there is approximately $6 million annually expended there.

Mr. CELLER. I do not want to frighten the members by making it too large.

Mr. MCCLORY. With respect to this suggestion—and I cannot help but feel that the bill recommends a sort of softening or at least a new

attitude toward narcotic addicts—I am concerned about that softening, especially insofar as any addict user might also be a seller. I am confused as between the person that you might refer to as a retailer and the other person as a wholesaler. I would think the retailer, as the one who would make a single sale, for instance, would be as vicious an element in our society as the one who was amassing a great fortune.

Do you distinguish between the retailer and the wholesaler?

Mr. CELLER. Yes, I think we would have to. The man who trafficks in drugs at the wholesale level, or who is a smuggler, generally is not an addict himself. I termed them vultures before. I have no sympathy with them at all.

On the other hand, take an addict who wants the drug and has not got the money to buy the drug. He will, when the pain besets him, do anything. A woman, for example, will indulge in prostitution to get money to buy the drug. I would not call her a trafficker or put her in the same category as the smuggler or wholesale purveyor. It is a quite different situation from those who buy the drugs and resell them. I would not put traffickers in the same position as the addict who is on withdrawal and suffers the pains of hell and must get that drug come hell or high water. There are distinctions you have to work out here and recognize.

Mr. MCCLORY. In my prior experience with this subject at the State level, and particularly with regard to penalties, I was concerned—and we were concerned in the State of Illinois—with regard to sales and gifts for that matter of narcotic drugs to minors. There would not be anything in here which would relieve any such person of any of the severe penalties recommended?

Mr. CELLER. We do not change the State laws on that subject. When you deal with minors most of the State laws are very severe.

Mr. MCCLORY. There would be nothing in the Federal law which would relax that penalty?

Mr. CELLER. No, sir.

Mr. MCCLORY. What do you regard as the coordinating agency? I notice that the Surgeon General has a part to play, the Attorney General, the U.S. district attorney, the Department of Health, Education, and Welfare, generally. What agency do you regard as the coordinating Federal agency to administer this law?

Mr. CELLER. The Surgeon General. I would recommend that the Bureau of Narcotics, for example, be transferred to the Department of Justice. It has no place in the Treasury Department. It was placed in the Treasury Department because, for example, the Harrison Act was deemed a revenue measure. The Harrison Act should not be deemed a revenue measure. But when it was passed it was deemed such. History has indicated that the Treasury Department should not be concerned with it. It is a matter for the Department of Justice.

The Department of Justice should have all the control over the activities of the Bureau of Narcotics. The Surgeon General should participate in the matter of the civil commitment together with the Attorney General because the Attorney General is the prosecuting officer of the United States.

Mr. MCCLORY. Is there any new office to be created, any new administrator or assistant?

Mr. CELLER. No, except I create an advisory committee on drug abuse, each member of which is paid a small stipend according to their services.

Mr. MCCLORY. Thank you.

Mr. ASHMORE. Thank you very much, Mr. Chairman, for your fine statement.

Mr. CELLER. Thank you.

Mr. ASHMORE. Our colleague Mr. McCulloch, the ranking minority member on the Committee on the Judiciary, has expressed his deep interest in this legislation. I ask that his statement be made a part of the record.

STATEMENT OF WILLIAM M. MCCULLOCH, REPRESENTATIVE OF THE FOURTH DISTRICT OF OHIO, AND RANKING REPUBLICAN MEMBER OF THE HOUSE COMMITTEE ON THE JUDICIARY

Mr. Chairman, the commencement of these hearings on narcotic addict control legislation is a step of great importance in the effort to immediately check and finally free the Nation from a cancerous growth. Addiction to narcotics now holds many of our citizens in its toils and threatens, if unchecked, to sap the energies of countless thousands of others. The scourge of narcotic drug addiction, fed by illegal traffic from sources outside the continental United States, presents a challenge not only in continuing to develop remedies to control it, but to help those poor unfortunates who find themselves helpless in its grasp.

THE 1965 NARCOTICS PROPOSALS

I introduced H.R. 8892 in June of last year. It is included in the bills pending beforethis subcommittee. Three other bills of my sponsorship are companion bills to it. They are pending before the Committee on Ways and Means (H.R. 8893) and the Committee on Interstate and Foreign Commerce (H.R. 8894 and H.R. 8895).

The provisions of these four bills are substantially identical to H.R. 9051 introduced by the able chairman of this committee, Mr. Celler. The administration proposal from the Department of Justice, H.R. 9167, is similar in content to H.R 8892 and H.R. 8893.

I have no exclusive pride of authorship in these proposals. The jurisdiction of the Committee on Judiciary may not extend to all of the bills. But, in considering any part of the package, the committee must be concerned with the four closely related areas to which my four bills and the chairman's bill address themselves:

(1) provision for civil commitment to cure certain Federal narcotic violators of their addiction, in lieu of prosecution for related offenses (H.R. 8892);

(2) a post-conviction procedure for the treatment of Federal addict-convicts together with adjustments to penalties provided by present Federal narcotics laws (in certain selected instances), to allow and encourage rehabilitation of addict offenders (H.R. 8893);

(3) provision for assistance to the States in developing programs and services for the treatment and rehabilitation of drug abusers, to include research at the State and Federal level (H.R. 8894); and

(4) provision for financial assistance to the States for construction of facilities for the same purpose (H.R. 8895).

FEDERAL NARCOTICS LEGISLATION

Mr. Chairman, I claim no expertise in the field of narotic trafficking or in narcotic addiction. I would not presume to suggest to the committee that there are neat, pat solutions to the problems of narcotic addition in the United States. But I would like to present some of the compelling considerations which must be given effect if we are to add to or modify present Federal narcotics laws.

It would serve a useful purpose briefly to note the recent history of the narcotic problem and the concern of Congress with it. It has been estimated that at the turn of the 20th century 1 out of every 400 people in our country was addicted to narcotic drugs. This figure assumes more significance when the

present estimates are considered: today 1 person out of every 4,000 is addicted. The first major Federal narcotic law was passed in 1909, the Opium Exclusion Act. The Harrison Act, which followed in 1914, is still the backbone of Federal narcotic criminal laws. Succeeding Congresses added to the Federal arsenal of controls and penalties in 1924, 1937, 1942, 1946, 1956, and 1960.

Of these enactments the most important in recent years, in reducing the incidence of addiction in the country, was the Boggs-Daniel Act of 1956. This act perfected mandatory minimum sentences with no possibility of parole or probation for convicted peddlers and smugglers. There is testimony in hearings before other committees of the Congress—as I am sure there will be here—to indicate that the strict mandatory sentencing provisions were largely responsible for a marked reduction in large wholesale drug operations and abandonment of such activities by organized crime.

It should be noted that this experience is but repetitious of the experience of several of the States, including my own State of Ohio. At one time, Ohio had a problem of drug addiction and drug traffic of as serious proportions as any State of the Union. Federal concern with the situation was well expressed by the fact that the Treasury Department's Bureau of Narcotics required some 20 men in the State alone. When the Ohio Legislature enacted laws requiring service of not less than 20 years for the offense of selling narcotics, the problem was all but eliminated. The Federal complement in Ohio presently is 3 men; the latest statistics indicate there are somewhat less than 500 addicts in the whole State.

THE NARCOTIC ADDICT

In contemplation of the law, addiction is a state of illness. Accordingly, the law can no more punish a man solely for being an addict than it can punish him for being a leper. *Robinson* v. *United States*, 370 U.S. 660, 666 (1961).

On the other hand, many authorities agree that it is the addict—not alone the pusher—who creates new addicts. The disease is therefore contagious, since every addict is a carrier. Criminal laws appropriately operate to control the spread of the infection. Such laws do not however cure addiction, as can readily be seen from the following generalizations.

The addiction itself is both physical and psychological. The addictive drugs—heroin and other opium derivatives—create a physical compulsion toward their consumption. Marihuana is not addictive in this sense, although a psychological dependence can be developed by repeated use.

The individuals who fall prey to these addictions are, in the main, from the lowest strata of our society. They share with most criminals the inadequacies of education, discipline, and, in short, a crippling lack of the sociological equipment required to participate constructively in society. The drug allows escape to a carefree, dream world, free from pressing unpleasant responsibility. In inducing complacence, self-indulgence, and avoidance of responsibility, drugs debilitate the addict, who then must seek an easy way to satisfy his deepening and irresistible desires. This, in a tragic number of cases, results in resort to crime.

In some cases, narcotic addiction is incidental to the crime. In others, the crime is most surely a product of illness, a result of hunger of the requirement for drugs. The latter hypothesis suggests that correction lies not in punishment but in cure. Any cure, to be successful, must reach not only the physical aspects of the ailment but the psychological underpinnings of the problem and the contributing sociological inadequacies of the addict himself.

REFINEMENT OF FEDERAL LAWS

The severity of the Federal laws together with increasingly effective work by the Treasury's Bureau of Narcotics have, in my judgment, proved highly successful in reducing the quantity of drugs smuggled into the United States and in restricting their circulation once they are in the country. But our great progress in this aspect of the problem brings into sharper focus other facets of the overall narcotics problem which command our attention in the bills proposed this year.

We know that stiff jail sentences rarely cure an addict of his dependence on drugs. We know that without medical and psychiatric treatment and rehabilitation, the released narcotics offender returning to his old environment will almost immediately return to drugs. Dwindling supply makes his life in quest of them more difficult; the crimes he must commit to satisfy his insatiable craving become more numerous and more desperate. In the meantime, to satisfy his

hunger for the mainline addictive drugs such as heroin or opium, he may resort to marihuana as well as amphetamines, barbiturates, and other dangerous drugs either to boost the effect of available drugs or to ease his discomfort from their deprivation.

Simply to lock the addict up for long periods, if he is otherwise susceptible to rehabilitation, is to throw away his life, and to perpetnate the additional waste that will result from his recurrent antisocial activity. What is required is not only treatment to cure his physical dependence on drugs, but adequate remedy for psychological dependency. Of overriding importance are adequate provisions for closely supervised aftercare to insure effective rehabilitation by a controlled reentry into a normal existence.

The present proposals are designed to add to our present laws the means whereby the addict who runs afoul of Federal law, and who can be cured of his addiction and rehabilitated to allow him to take an active constructive part in our society, will be identified and treated for the underlying cause of his lawlessness. In so doing, however, the stringent prohibitions against the import and sale of drugs must not be weakened.

Civil commitment for narcotics offenders (H.R. 8892) offers an alternative to harsh prison penalties for the suspect who agrees to submit to a program of rehabilitation. The prosecution is held in abeyance for the period of supervised treatment and aftercare, which may last for up to 5 years.

Improvements in post-conviction treatment of all addicted offenders (H.R. 8893) provides for more flexibility in the treatment of addict-convicts by allowing utilization of parole (after service of mandatory minimums) and allowing utilization of a wide range of facilities for treatment and rehabilitation.

ASSISTANCE TO THE STATES

It is quite obvious that every addict in the Nation is not a responsibility of the Federal Government. Control of the traffic in drugs depends upon the close cooperation of Federal and State authorities. Proper Federal interest, however, lies chiefly with importers, interstate traffickers, and those addicts who commit Federal crimes. In my judgment, however, the Federal share and responsibility for this problem go beyond the mere number of addicts whose activities bring them under Federal criminal jurisdiction.

First, Federal participation is primarily indicated by the relation of the source of addictive drugs to the individual States: it is a Federal customs responsibility to control illicit imports.

Secondly, as my remarks about my State of Ohio have suggested, States which have cured their problems by enactment of stringent penalties and other measures, in many cases, have simply shifted the problem from within their borders to another State where conditions exist more favorable to the maintenance of a narcotic habit. The complexion of the problem has been a changing one in the past. Tightening controls against importation by sea have already resulted in an increase of illicit traffic over our land borders, both north and south. Few States are completely insulated from future contaminations.

Thirdly, as the availability of the "mainline" drugs is reduced, addicts are resorting to use of amphetamines, barbiturates, and other dangerous drugs wherewith to satisfy their appetites. Regulation of these latter substances is distinctly a Federal concern as the passage of the Drug Control Act of 1965 indicates. The relationship of dangerous drugs to narcotics, in my judgment, is becoming so close that the problems of the two are nearly inseparable.

In short, a compelling requirement exists for a continuing coordination of the States in the solution of the problem, and a concerted, comprehensive research program to explore the causes of drug addiction. We must better understand its effects on the human mind and personality, and develop and assist in putting into operation rehabilitative measures for the relief of many addicts powerless to help themselves.

CONCLUSION

The immediate Federal interest in law enforcement can well be served by flexible and enlightened machinery for the rehabilitation of addicts who stand charged with or convicted of Federal crimes and can be restored to effective and useful citizenship. Such a program may well speed refinement and full implementation of similar programs already existent, and encourage other States to adopt comprehensive means for rehabilitating addicts.

Finally, direct Federal assistance to the States, which presently have the greatest number of addicts, can enable them to mount a more effective attack on the problem. The best interests of the Nation will be served by a coordinated and concerted attack on the ignorance of the causes, the nature, and the cure for narcotics addiction—scientific and public—which surrounds, stifles, and chokes the addict, ultimately relegating him to a life of misery in a foreign, friendless, and shadow world.

Mr. ASHMORE. Now we shall hear from the Attorney General, Mr. Katzenbach.

You may proceed.

STATEMENT OF ATTORNEY GENERAL NICHOLAS deB. KATZENBACH

Mr. KATZENBACH. Mr. Chairman, I am accompanied here this morning by Mr. Howard P. Willens, First Assistant in the Criminal Division.

I have a prepared statement. Would you like me to proceed with it?

Mr. ASHMORE. Yes, go right ahead, please.

Mr. KATZENBACH. Mr. Chairman, I appreciate the opportunity to appear here today in support of H.R. 9167, the Narcotic Addict Rehabilitation Act of 1965.

Crime is hacking away at the fabric of American society. Since 1958, the crime rate has increased five times faster than the population. Its cost in dollars is in the billions. The costs in human loss and misery are immeasurable.

The fight on crime cannot be separated from a fight on narcotic addiction. Organized crime profits on the spread of this disease. Desperate drug takers often resort to crime to feed their addiction. To give more addicts a way to rid themselves of the ravages of the disease, therefore, is also to provide strong ammunition to the fight on crime.

Narcotics addiction has received much attention in the last several years. A White House Conference on Narcotic and Drug Abuse was held in 1962. A highly qualified Commission under the distinguished chairmanship of Judge E. Barrett Prettyman was appointed by President Kennedy to follow up the conference discussions with specific recommendations. As you know, numerous bills have been introduced into the Congress on the problem.

The recommendations stemming from these conferences, studies, and legislative proposals have identical goals—the treatment of narcotic addicts who give promise of being rehabilitated. The able chairman of the House Judiciary Committee has introduced such legislation, as have other Members of the House. Similar bills have been introduced into the Senate.

The basic purposes of H.R. 9167 are identical to many other bills now before this committee. It implements one of the key objectives stated by President Johnson in his message to Congress on law enforcement and the administration of justice. In his message the President said:

The return of narcotic and marihuana users to useful, productive lives is of obvious benefit to them and to society at large. But at the same time, it is essential to assure adequate protection of the general public.

H.R. 9167 is carefully designed to satisfy both aims—the rehabilitation of narcotic addicts and the protection of the public. The Depart-

ments of Justice, the Treasury, and Health, Education, and Welfare collaborated in the preparation of its specific proposals. It was drafted only after closest study of narcotics addiction, a complex subject which cuts across the boundaries of many disciplines—criminology, sociology, psychology, as well as medicine, pharmacology, and the various biological sciences.

This legislation represents a fundamental reorientation toward the problem of addiction. Because it is a problem that is dangerous and sordid, we have until now put all our eggs in one basket. We have too long stressed punitive solutions and neglected medical and rehabilitative measures.

The Bureau of Narcotics has done a magnificient job in cutting the illegal traffic in narcotics and bringing to justice the vicious racketeers who exploit the needs of addicts.

But though the work of the Bureau effectively attacks this aspect of the problem, it cannot strike at another basic aspect—the permanent rehabilitation of addicts.

H.R. 9167 is directed toward this fundamental aspect of the narcotics problem. There is hopeful evidence that future innovations as well as a fuller utilization of known techniques can return a far higher percentage of addicts to a useful role in the community.

The legislation follows many of the recommendations of the Prettyman Commission. It is carefully balanced. While it provides a new and more open approach to addiction, it contains adequate safeguards. H.R. 9167 represents not a large step, nor a dangerous step, but a progressive step. It allows us to treat criminals as criminals but allows us to treat addicts when they can be rehabilitated. It provides an excellent process by which those who can be helped are selected from those who cannot or those who may be dangerous. It is also flexible, leaving adequate room to meet the changing manifestations of this disturbing problem.

H.R. 9167 as three titles, which I shall first briefly summarize and then discuss in greater detail.

Title I offers narcotic addicts charged with a Federal offense the choice of civil commitment to medical treatment prior to and instead of a criminal trial.

Title II authorizes an indeterminate sentence for treatment not to exceed 10 years for selected narcotic addicts convicted of any Federal offense.

Title III makes parole available to all marihuana offenders. It makes sentencing under the Federal Youth Corrections Act available to all marihuana or narcotics offenders under the age of 26.

Title I: Estimates of the number of drug addicts in the United States vary from 45,000 to 100,000. The Narcotics Bureau placed the figure at 56,000 at the end of 1964. Most live in a strange, melancholy world marked by squalor and desperation.

There is substantial evidence to indicate that addiction is primarily an emotional problem. Addicts tend to immaturity. They have strong feelings of futility and a sense of failure. They are weak and unstable.

Physiologically, even a long-term heroin addict can be rid of his symptoms in a short time. That is to say, his body no longer requires the drug. Emotionally, however, his need is as great as ever.

The emotional problems and lack of self-discipline that characterize addiction have led those experienced in the problem to these conclu-

sions: There are some addicts who have the willpower necessary to finish the required treatment voluntarily. Voluntary treatment should continue to be available for addicts against whom there is no criminal charge. Most addicts, however, will leave unless continued treatment is compulsory.

These addicts cannot be permitted to discontinue treatment at their own option. They must also be supervised during an extended period of rehabilitation following their release from an institution. These consideration underlie the provisions of title I.

A recent study of some 1,900 addicts who were discharged from the Public Health Service narcotic hospital at Lexington found that only 10 percent had not returned to the use of drugs. The rest relapsed, mostly within 6 months of leaving the hospital. The majority of patients at Lexington are there on a voluntary basis. They can leave at any time, and most do so a short time after being "cured."

Under title I an individual charged with any offense against the United States is offered the choice of civil commitment instead of criminal prosecution, if the court believes him to be a narcotic addict. The choice must be made within 5 days after the individual's first appearance in district court, except when compelling reasons are shown to the court.

The court informs the individual that if he chooses civil commitment, he will be examined and may then be held in custody for treatment for up to 3 years. If the necessary treatment is completed satisfactorily, the criminal charge against him is dismissed. If it is not, prosecution is resumed. The provisions of the Criminal Justice Act of 1964 providing counsel are available to him.

If the individual chooses civil commitment, he is committed to the Surgeon General for examination. The Surgeon General reports his recommendations back to the court within a 60-day period.

The medical and other evidence presented to the judge must show that the individual is likely to be rehabilitated. This is an important factor in the program, without which its success would be problematical.

If the court rules that the individual is likely to be rehabilitated, it may commit him to the Surgeon General for a period of treatment not exceeding 3 years. This period may include time spent in conditional release under supervised care in the community.

Once the individual is committed to the Surgeon General for treatment, the entire program is under his jurisdiction. The Surgeon General prescribes treatment in the institution and determines the conditions under which the individual may be conditionally released for treatment in the community.

The individual does not report back to court except under the following circumstances:

1. If the Surgeon General has not conditionally released the individual after 2 years, he must inform the court and the U.S. attorney, and recommend whether treatment should be continued. The court may then reaffirm the commitment or terminate it and resume the pending criminal proceeding.

2. If a conditionally released individual returns to the use of narcotics, the Surgeon General must report the fact to the court and recommend whether treatment should be continued. The court may then reaffirm the commitment or terminate it.

3. The Surgeon General may at any time during treatment advise the court that the individual cannot be further treated as a medical problem. The court must thereupon terminate the commitment.

If the criminal proceeding is resumed, the individual receives full credit toward the service of any sentence imposed for the time he spent in the institutional custody of the Surgeon General.

The determination of addiction and subsequent civil commitment is not considered a criminal conviction. The results of any tests conducted during treatment to determine addiction may be used only in a further proceeding under this title.

The great advantage of pretrial civil commitment lies in its emphasis on swift medical and rehabilitative treatment. Addiction is spread by addicts themselves. Keeping them off the street in itself represents an important obstacle to the further spread of addiction.

In the absence of a meaningful pretrial program, addicts who are indicted in the Federal system have two alternatives pending trial: imprisonment, normally without treatment, or returning to the community on bail. This legislation offers the addict not only a means of medical treatment but an opportunity to avoid the stigma which attaches to a trial and possible conviction.

All addicts indicted by the Federal Government, who are considered to be good prospects for treatment are eligible, whether or not they are charged with a narcotic offense. There are, however, certain important exceptions: Individuals charged with crimes of violence; individuals charged with selling drugs for profit rather than as a means to support their own addiction; individuals with a prior felony charge, the outcome of which has not been determined; and finally, individuals with two or more convictions of a felony or two or more previous civil commitments.

We believe it extremely important to make all other addicts eligible. Addicts frequently support their addiction by crime. The close relationship between addiction and crime is easily seen in information available on Federal prisoners. Between 1960 and 1963, 43 percent of all convicted addicts in Federal institutions violated laws other than narcotics and marihuana statutes.

Title II: Title II provides for the sentencing of addicts to treatment after conviction. If the court determines that the convicted offender is an addict likely to be rehabilitated through treatment, it may commit him to the custody of the Attorney General for an indeterminate period up to 10 years. The period of commitment may not, however, exceed the maximum sentence that could otherwise have been imposed.

Title II makes treatment available to addicts who do not choose civil commitment or who are not chosen for or do not complete the civil program. In the latter case, unsuccessful treatment does not conclusively point to subsequent failure.

The maximum 10-year sentence allows correctional and medical authorities flexibility in treating individual addicts. At the same time, it provides a lengthy sentence for recalcitrant offenders who do not respond to treatment. As in title I, an addict convicted of any Federal offense with certain exceptions is eligible for treatment.

Under title I the Surgeon General, and under title II the Attorney General, have broad authority to contract for community care. Such

contracts may involve individuals, State and local parole authorities, halfway houses, or local clinics and centers, public as well as private.

Civil commitment for addicts has been introduced in California and in New York. The California law became effective in 1961, the New York law in 1963.

The California law was enacted after an experimental program proved successful. Fifty-two percent of the addicts treated under this program were neither detected using narcotics nor convicted of any crime within 6 months after their release. While it is too early to judge the success of the California law's operation in statistical terms, many former addicts paroled to a community care program have remained in the community under supervision without returning to narcotics.

The individuals who have remained off drugs include former hard-core addicts. One such man began using marihuana at the age of 12 and later switched to heroin. He used up to 6 grams, or about $75 worth a day. He had a long history of arrests prior to being committed to the rehabilitation center, but has not returned to crime or addiction since his release.

Another addict also began using marihuana at the age of 12 and later switched to heroin. He used heroin for 10 years, taking as much as 1 gram of 79 percent pure heroin a day (an extremely high dosage) while in the service in Japan. He has not relapesd to drugs since his release in July of 1963.

Title III: Title III provides an alternate sentencing procedure for marihuana offenders. It makes them eligible for parole. Marihuana is not addictive, and its users require different kinds of treatment than individuals addicted to narcotics. This provision acknowledges this well-recognized difference, as did the Prettyman Commission.

Title III also extends the indeterminate sentencing provisions of the Federal Youth Corrections Act to all narcotic and marihuana offenders under 26 years of age. This extension explicitly recognizes that youthful offenders can be helped in conforming to the rules of society and that the youthful offender should be allowed to extricate himself from early mistakes. Successful completion of the treatment program under the Youth Corrections Act results in the conviction being set aside.

Committing youthful offenders to the custody of the Attorney General for treatment is at the discretion of the court. But before committing those between 22 and 26, the court must commit the young offender to the custody of the Attorney General for observation and study. The court must then find that grounds exist to believe that the defendant will benefit from the treatment.

Finally, under title III, the Board of Parole is directed to review the records of all marihuana offenders and narcotic offenders who were under 26 when convicted and who are not now eligible for parole.

The Board can grant parole to these individuals if they have served one-third of their sentence. Those who were under 26 at the time of conviction may, at the discretion of the Board, be placed in the custody of its Youth Division for treatment. The concept of reviewing sentences stems from a recommendation by the Prettyman Commission. It is designed to allow individuals now in prison the same

opportunity as those who will appear in court subsequent to passage of this legislation.

H.R. 9167 combines flexibility with adequate safeguards. It places emphasis on addiction as a sickness. It gives the courts and correctional authorities ample scope to provide the most appropriate treatment. At the same time, it excludes those who commit acts of violence, repeated offenders, those who make a business of selling narcotics, and those who are judged unable to profit from treatment. No addict can be committed if the Surgeon General or Attorney General believes adequate treatment facilities or personnel are not available.

Strong public support has enabled science to conquer many of the terrible diseases which afflicted man in the past. We are continuing an all-out effort against heart disease, cancer, and other maladies as yet undefeated.

Drug addiction is a fearful disease of mind and body no less damaging and no less deserving of our attention. This legislation, I am convinced, represents our best current hope to halt its eroding effect on our society.

Mr. ASHMORE. Thank you, General. Your bill does not provide, I believe, any funds for the construction of additional institutions?

Mr. KATZENBACH. No, it does not.

Mr. ASHMORE. Do you think that the Federal Government now has sufficient places to treat these people and rehabilitate them?

Mr. KATZENBACH. I think we do at the moment, Mr. Chairman. We are making full use of our institutions. I think we should do that. In addition I believe that under existing law HEW has adequate authority to take care of these problems and even to help the States with respect to various hospital, clinic, and mental health facilities which could be used in this program.

Mr. ASHMORE. I believe section 105 of the bill states:

> The Surgeon General may from time to time make such provision as he deems appropriate authorizing the performance of many of his functions under this title by any other officer or employee of the Public Health Service, or with the consent of the head of the Department or Agency concerned, by any Federal or other public or private agency or officer or employee thereof.

He would not have authority to use a State institution, would he?

Mr. KATZENBACH. Under that provision?

Mr. ASHMORE. Yes.

Mr. KATZENBACH. I believe so.

Mr. ASHMORE. I didn't read the next section.

> The Surgeon General is authorized to enter into arrangements with any public or private agency or any person under which appropriate facilities or services will be made available, on a reimbursable basis or otherwise for the examination or treatment of individuals who elect civil commitment under this title.

Mr. KATZENBACH. That is not a construction provision but a contracting out provision.

Mr. ASHMORE. Do you think that is better than the provision of Mr. Celler's bill?

Mr. KATZENBACH. I think we are dealing with different problems. I am not opposed with the provisions in Mr. Celler's bill, but I believe that HEW has under existing law adequate authority and would have adequate money with appropriations to meet any of the needs that are described in Mr. Celler's bill. I think under the Hill-Burton Act,

the hospital acts, under recent legislation with respect to mental health centers, it could be handled in that way. HEW can testify more fully on that than I.

Mr. ASHMORE. The Federal Government now has two institutions?

Mr. KATZENBACH. Yes; one at Lexington and one at Fort Worth.

Mr. ASHMORE. Do you know what the population there is, the approximate number?

Mr. KATZENBACH. I don't have the figures with me, Mr. Chairman. I can say they are not being fully and completely utilized for the treatment of narcotic addicts.

Mr. ASHMORE. They are not fully utilized?

Mr. KATZENBACH. For that purpose, no.

Mr. ASHMORE. Let us get clear just who is eligible for commitment to an institution. The addict is eligible.

Mr. KATZENBACH. Yes.

Mr. ASHMORE. In a general way.

Mr. KATZENBACH. An addict who has committed any Federal crime is eligible for a civil commitment, and then we except crimes of violence, people who have committed two felonies, and people who have a felony charge pending against them at the time the new charge is pending.

Mr. ASHMORE. In other words, an addict, if he has committed a violation of the Mann Act, stolen an automobile, a Federal offense, he would not be eligible for commitment?

Mr. KATZENBACH. Yes; he would be.

Mr. ASHMORE. He would be?

Mr. KATZENBACH. Yes; under the administration bill he would be.

Mr. ASHMORE. Under your bill he would be——

Mr. KATZENBACH. Under our bill he would. He would not be under Mr. Celler's bills: Our bill is broader in that respect than Chairman Celler's bill.

Mr. ASHMORE. Will the person who trafficks or sells, buys and sells, drugs be eligible for commitment?

Mr. KATZENBACH. He is eligible only if the sales that he made were made necessary to support his own addiction. If he was making further profit or pushing in a further way than that he would not be eligible.

Mr. ASHMORE. That is what I am trying to get at. The person who is not an addict but is in the business to make money, buying and selling, he is not eligible for commitment under this bill.

Mr. KATZENBACH. He is eligible for just as long a sentence as we can give him.

Mr. ASHMORE. I agree with you 100 percent. Suppose he has done both?

Mr. KATZENBACH. If he is doing both he is still not eligible for the civil commitment. He is eligible for that only if he has made sales and they are clearly related only to supporting his own addiction and nothing more.

Mr. KING. How do you determine that under your bill?

Mr. KATZENBACH. It is determined by the judge. If he would say, as Mr. Celler says, that anybody who takes it for resale is to be excluded from this, we would then be excluding people who make only three or four sales that they need to get the money for their own dosage and

who are not really trying to push this but who are simply desperate to get their own dosage. We believe if it can be established that that is all the man has done, he might have made one or two sales but they were just related to getting his own dosage and nothing more, then he should be eligible.

Mr. KING. How is that proven?

Mr. KATZENBACH. Well——

Mr. KING. Must the authorities prove that to the judge or is it up to the defense to prove it?

Mr. KATZENBACH. If he has been charged with selling, there is evidence that he was selling, it would be up to him to establish that these are the only sales he had made.

Mr. MCCLORY. If the gentleman would yield to me on that.

Mr. KATZENBACH. He has to satisfy the court that that is all he has done. We might be satisfied as to that conceivably if we knew the man, if informants told us this was the situation, that he was not active in this, we might be satisfied in that way, but I would think generally it would be up to the man who had been charged and caught selling, it would be up to him to try to establish that he really was not in the business of selling.

Mr. ASHMORE. General, I believe on page 12, subsection 2 of your bill, in the definition section, this is perhaps the best statement on that. Under eligible offender:

An offender who is convicted of selling a narcotic drug unless the court determines that such sale was for the primary purpose of enabling the offender to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug.

Mr. KATZENBACH. Yes.

Mr. ASHMORE. The Celler bill, on the other hand, simply says the—

provisions of this act shall not be applicable in the case of any person charged with selling narcotics to another for purposes of resale.

Mr. KATZENBACH. That is right. I think the difference is small but it exists. He excludes some people that we would make eligible.

Mr. ASHMORE. In either case, it is up to the presiding judge to determine what the purpose was?

Mr. KATZENBACH. Yes. I would suppose that to aid in making that determination we could, for example, make available investigative reports to the judge.

Mr. ASHMORE. I am sure you could and that you would need those. Under title II, page 5 of your statement, you state:

Fifty-two persons of the addicts treated under this program were neither detected using narcotics nor convicted of any crime within 6 months after their release.

This referred to the California law.

Would you call that a successful program in that case?

Mr. KATZENBACH. Yes. The short answer is yes. It doesn't sound it, Mr. Chairman, but if you compare that with 90 percent in our voluntary program in the Federal institutions who return to the use of narcotics.

Mr. ASHMORE. Only 10 percent under the voluntary Federal program stay away from it?

Mr. KATZENBACH. That is right.

Mr. ASHMORE. In other words, 90 percent do return?

Mr. KATZENBACH. That is right. Here only 48 percent have returned. Most of them return within 6 months. I think if you take another 5-year period under the Federal program it gets up again to about 95 percent.

Mr. ASHMORE. You state while it is too early to judge the success of the California law's program, many former addicts paroled to a community care program have remained in the community under supervision without returning to narcotics.

Under whose supervision are they?

Mr. KATZENBACH. Under State authorities. There are a number of community mental health centers which administer their program and they keep an eye on the addict who comes in from time to time. They look at him from time to time. It is not unlike a parole supervision or a probation supervision except for the fact that here it is related medically rather than criminally.

Mr. ASHMORE. What are the community care centers? What is the nature of them? They are in different areas of the State, I suppose?

Mr. KATZENBACH. That is right. They are moderately small and they are located within the various communities. I do not know the exact number they have in California now but it is quite a number.

Mr. ASHMORE. And it would require a good many, particularly in California, which is a large State?

Mr. KATZENBACH. California is one of the major areas of narcotic addiction. If you took care of California and New York you would take care of about two-thirds of the problem.

Mr. ASHMORE. Is that so? Has New York law been as successful as California?

Mr. KATZENBACH. It has been in operation for only 2 years. It seems to me too early to make a judgment on that, Mr. Chairman. In fact, it is really too early to judge the California law, to be completely candid about it, but it seems to be making some progress.

Mr. ASHMORE. When an addict under this voluntary program is committed up to 6 months—I believe that is the maximum for the first commitment?

Mr. KATZENBACH. No. Under the civil commitment it is 3 years.

Mr. ASHMORE. He could be committed for 3 years in one term?

Mr. KATZENBACH. That is right. He does this voluntarily. He is then under the supervision of the Surgeon General for 3 years. He could spend all of that time in an institution. Once he is in, he is in.

Mr. ASHMORE. Is the Celler bill the same in that respect?

Mr. KATZENBACH. Yes.

I am told it is 5 years under the Celler bill.

Mr. ASHMORE. Three years commitment and then he is under supervision, or parole, for 2 more years?

Mr. KATZENBACH. Yes; under our bill it is 3 years for the whole process.

Mr. ASHMORE. When he is committed for this 3-year term, although the judge might think twice in giving him the full 3 years in the original commitment. he could be released by the Surgeon General?

Mr. KATZENBACH. The Surgeon General can release him. However, supervision could continue for the full period of time.

Mr. ASHMORE. I am wondering, General, about this: Say a man is committed for 3 years and he is released in 2 years, they feel he has been rehabilitated and he can go back to society as a normal person. Then he commits another offense. He violates the narcotics law again. Then he comes up for trial, more than likely he would. I presume he could be recommitted.

Say he came up for trial. The judge has decided he is no longer a fit subject for rehabilitation. You have two and a half years which have passed. How will you prosecute? Don't you run into a tremendous risk there in matter of time, getting witnesses, unless he may agree to a speedy trial?

Mr. KATZENBACH. I agree.

Mr. ASHMORE. How will the Government prosecute?

Mr. KATZENBACH. It would be difficult after two and a half years in many instances to prosecute for the reason that you suggest, Mr. Chairman, although now in New York it is 9 to 12 months before you get the trial, anyhow. I suppose in many cases we still would have the witnesses. Many of the witnesses in these instances are narcotics agents who still would be available to testify.

I don't want to avoid the fact it creates a problem. I think you have to make a choice there of whether it is worth it. I believe it is. Take that risk in these selected cases because it gives an added incentive to the addict to attempt to go through this process, attempt to be cured. He will get not only a cure in his addiction but vocational training and other things which will help him to come back into the community, particularly in the case of young people and first offenders, where this is the first time they have gotten into trouble. It may add a sufficient incentive as well as the coercion during the whole time he is there to warrant it. That would be my judgment. But it has the difficulty the chairman points out.

Mr. ASHMORE. You think it is worth taking a chance?

Mr. KATZENBACH. I think it is worth taking a chance.

Mr. ASHMORE. I am wondering about the number successfully treated in Federal institutions and those treated under California law. How do you account for the great difference in the number cured?

Mr. KATZENBACH. Two ways. Statistics in Lexington are largely of those who came in voluntarily to be cured and who were free to leave at any time thereafter, and many of whom I feel left before the Surgeon General would have certified that he was cured.

Second, there is no aftercare treatment for those people. I think the toughest time to stay off is the point at which they return to the community and return to the stresses that have led them to drug addiction in the first place.

It is similar with crime as well as addiction. Most criminals if they are going to repeat will repeat in the first 6 months after they are out of a Federal institution.

Mr. ASHMORE. Any criminal, as a general statement?

Mr. KATZENBACH. Any criminal. Getting back into the community, if they can hold a job, stay off drugs, if they have the support of some further treatment and further supervision, if they stay off for 6 months they have a better chance of staying off entirely.

That is done in California. I think those two factors, the nonvoluntary aspect, the fact they have to stay until somebody else says

they can leave, and then subjecting themselves to this care, that would be my guess as to the reason for the difference.

Mr. ASHMORE. Do you know whether or not there is any difference in the treatment that they are receiving at Lexington and that which they receive in the California institution? Is there any improvement which Lexington is not aware of?

Mr. KATZENBACH. The Surgeon General can answer it better. I think Lexington is a fine institution medically and professionally. I doubt if there is any better in the country.

Mr. ASHMORE. Then it would appear that the key to the permanent cure is the aftercare treatment.

Mr. KATZENBACH. Aftercare treatment and keeping them there long enough. You can get off the physiological aspects of this fairly quickly and fairly successfully, and then you can regard yourself as cured since you have been off it for a while. I think the psychological pressures there lead these people to return to drug addiction. It is treatment in that respect they need, and a further understanding of themselves and the reason for their addiction, and the aftercare program.

I have heard members of this committee say they didn't know a great deal about drug addiction. The truth of the matter is, Mr. Chairman, that nobody does.

Mr. ASHMORE. I am afraid that is right.

Mr. Celler's bill, I believe, recommends that all narcotic cases be transferred to the Department of Justice, in other words, taking them away from Treasury and putting it all under your Department. I don't want to put you on the spot, but ultimately that has to be answered and we want to know what you think about it.

Mr. KATZENBACH. I think the Narcotics Bureau is a fine agency and I think they are doing a fine job right where they are. We have no trouble cooperating with them.

Mr. ASHMORE. You don't want any more business, then.

You stated, and I have heard before, that marihuana is not a habit-forming drug. Is that correct?

Mr. KATZENBACH. That is right. Many marijuana users end up subsequently leading up to heroin, so it has the effect of leading one into addiction, but it is not addictive in itself.

Mr. ASHMORE. How about those who use it? The effect of it is unknown, is it not? It can cause one to commit murder, another sex violence, another something else?

Mr. KATZENBACH. That is right.

Mr. ASHMORE. In many ways it is as bad as heroin, morphine, and what have you?

Mr. KATZENBACH. From that point of view it is.

Mr. ASHMORE. Is there any difference in your bill with reference to a person who is using or dealing in, buying or selling and smuggling marihuana and heroin and other narcotics?

Mr. KATZENBACH. Not so far as people pushing marihuana as against heroin. The only difference we have is that we would permit parole procedures for marihuana violators.

Mr. ASHMORE. You would?

Mr. KATZENBACH. We would permit parole where there is presently a minimum sentence required on marihuana. We would permit parole on marihuana only.

Mr. ASHMORE. You would change the penalty in the present law?

Mr. KATZENBACH. To the extent of permitting parole, yes, sir.

Mr. ASHMORE. They are barred from parole at the moment?

Mr. KATZENBACH. That is true. They are not eligible under the civil commitment section of the statute because they are not addicts.

Mr. ASHMORE. Your bill would make them eligible for parole and for commitment?

Mr. KATZENBACH. No, because there is no addiction. They don't need it.

Mr. ASHMORE. No psychological treatment you know of?

Mr. KATZENBACH. Most of the marihuana users, if they are not also users of other drugs, have not gotten to that stage, are mostly youthful offenders and sort of doing it for kicks, I guess.

They just started down the road.

Mr. ASHMORE. I believe your bill and Mr. Celler's bill both have an age limitation, minimum of 22 and a maximum of 26?

Mr. KATZENBACH. Yes, we do have such provisions in that with respect to the sentencing of certain narcotic or marihuana offenders under the Federal Youth Corrections Act.

Mr. ASHMORE. Can you tell me why you confine it to those ages?

Mr. KATZENBACH. Mostly because the people between 22 and 26 are better prospects for rehabilitation than older people.

Mr. ASHMORE. How about those who are not yet 22?

Mr. KATZENBACH. They are already eligible for sentencing under that act. The only thing this would do would be to extend the upper limit to 26 for the sentencing of these narcotic or marihuana offenders.

Mr. ASHMORE. Counsel suggests we might go a little more in detail on this delay in trial. Are you satisfied as to that?

Mr. KATZENBACH. I am satisfied where there is a conscious waiver by counsel with a knowledge of the defendant in the case.

Mr. ASHMORE. Mr. King asked Mr. Celler this: If he is a confirmed——

Mr. KATZENBACH. No request——

Mr. ASHMORE. Can he voluntarily agree to waive trial?

Mr. KATZENBACH. Yes, he can, Mr. Chairman. If we were to say he could not we couldn't even try him.

Mr. ASHMORE. That is true, too. Also I note in this bill that the judge turns him over to the Surgeon General for 10 days or 5 days?

Mr. KATZENBACH. Mr. Celler——

Mr. ASHMORE. This is before he has made a statement regarding waiver. Would they examine him, some medical expert, during that time and say he was in a position to know what was right from wrong?

Mr. KATZENBACH. Yes. The purpose of that provision, 60 days in our bill and 10 days in Mr. Celler's bill——

Mr. ASHMORE. Sixty days in your bill?

Mr. KATZENBACH. Yes. The purpose of that is to make the examination that is necessary to inform the court whether or not you think this person is a good bet.

Mr. ASHMORE. That is before he agrees to voluntary commitment.

Mr. KATZENBACH. He goes in first and says, "I want civil commitment."

Mr. ASHMORE. And he says that when?

Mr. KATZENBACH. He says that within 5 days of the first appearance before the district judge. He comes in and says, "I want civil commitment." We then examine him for a period of time, under our bill up to 60 days, and report back to the judge and tell the judge whether or not the Surgeon General thinks there is a good prospect of cure in this case. If he does not believe there is, we go ahead and proceed to trial. If the Surgeon General recommends it to the judge, the judge still passes his own judgment on the matter and decides yes or no.

Mr. ASHMORE. The Celler bill provides only 10 days.

Mr. KATZENBACH. Only 10 days, which we think is too short a period of time to make a determination of that kind. We think ordinarily 30 days would be about right, but——

Mr. ASHMORE. You indicated 60, thinking you would end up with 30 days?

Mr. KATZENBACH. I think it ought to be just what we recommended, Mr. Chairman. I think 60 days is fine.

Mr. ASHMORE. I think 10 is too short. I agree with you. It is 30 plus an additional 30.

Mr. KATZENBACH. It is 30 plus 30, yes.

Mr. SENNER. I would like to commend the distinguished Attorney General for his usual fine statement in this regard and others.

Mr. KATZENBACH. Thank you, Mr. Senner.

Mr. SENNER. In regard to your statement on page 3, the fifth paragraph, where an individual chooses the civil commitment procedure, you state that the custody is set for a period of 3 years. First, I want to ask you why was 3 years chosen as the period?

Mr. KATZENBACH. It was chosen because it is related to the period of aftercare that would seem to be appropriate, and it was chosen because 3 years is a pretty good, long time for a fellow to commit himself to involuntary custody of this kind. In other words, we wanted the penalty on him, if you want to call it that, his loss of freedom, to be pretty stiff and for him to recognize that, because it seemed to us if he took a free, voluntary recognition of that rather than go to trial, he might be a better prospect for rehabilitation.

Mr. SENNER. I do not have any objection to the 3-year period if it is what the experts recommend, except perhaps maybe to insert the words "not to exceed 3 years," on the possibility that there would be a criminal conviction and the maximum sentence would be 1 year. Here is this prospect who would weigh the time that he would be incarcerated or fined or subject to the jurisdiction of the Federal Government or the State government, and he might not be desirous of taking the civil procedure route.

Mr. KATZENBACH. I think very few addicts would come in on that. At least, the maximum penalty would be 1 year for most of our Federal offenses. An addict is likely to be involved with considerably more. Even the Dyer Act cases run 5 years at the maximum. I would suppose it would be unusual that that would occur. I still would want to leave it at 3 years. He is taking it voluntarily as a choice. If it is only a 1-year offense, he may be unlikely to take that, but it will not

come up very often and we cannot do much for him in a 1-year period.

Mr. SENNER. I agree, from an examination of the Commission's report, but could we improve the bill by saying "not to exceed 3 years" and leave it to the determination of the judge, and not make it mandatory in the bill?

Mr. KATZENBACH. If you said "not to exceed 3 years," I would not have an objection to that. I would hope that that determination could be made by the Surgeon General as to when he should be completely released, rather than the Surgeon General being put under some sort of judicial order to cure him in 18 months, which might not be possible.

Mr. SENNER. Counsel has called to my attention that that bill says not to exceed 36 months. That answers my question.

The chairman of this subcommittee touched upon the next to the last paragraph where you state:

> The Surgeon General prescribes the treatment in the institution and determines the condition under which the individual may be conditionally released for treatment in the community.

Again, going back to the question I asked the chairman of the full committee, would this give authority to the Surgeon General to contract with a private hospital for the care and treatment of a drug addict, rather than going through a Federal or State clinic or halfway house or some other facility?

Mr. KATZENBACH. He can contract with any hospital. Section 105, "any public or private agency or any person under which appropriate facilities or services of such agency or person may be made available," He could contract with a private hospital if that were what he deemed to be advisable.

Mr. SENNER. I ask that question because we have a great number of small communities. I am not implying there are drug addicts in each one of these communities, but if they had private physicians authorized by the Surgeon General then, perhaps, we could provide better treatment for the individual, which is what we are interested in.

Mr. KATZENBACH. He could do that. He could contract with any local hospital facility or medical facility of that kind. In fact, he could contract with our parole and probation service to supervise him.

Mr. SENNER. The President's Advisory Commission final report, on page 57, contains the following language:

> The Commission recommends that Federal regulations be amended to reflect the general principle that the definition of legitimate medical use of narcotic drugs and legitimate medical treatment of a narcotic addict are primarily to be determined by the medical profession.

Going down and reading some of their recommendations, in certain instances they recommend continued treatment of a drug addict with narcotics. Do you agree that this is the proper way perhaps to work with the sociological and psychological aspects of the individual you are trying to help?

Mr. KATZENBACH. Yes, I do, Congressman, but I would like to qualify my answer a little bit on that. I think this is a medical problem and it is a difficult medical problem. The Narcotics Bureau is presently working with the American Medical Association on a revision with respect to its regulations in this regard. There is a joint

statement they have made, the gist of which is that the medical profession is extremely skeptical that continuous dosage of narcotics is useful in cure. They feel this for three reasons. One is that it is almost impossible not to increase the dosage as the person develops some resistance to it. Secondly, there are nonnarcotic substitutes which are available to take a person through this period, which are generally superior to using the narcotic itself. Thirdly, very few people can behave normally when under the influence of narcotics. There are some people who can behave normally in this way, but they are relatively few of those addicted.

The medical profession is skeptical of any general theory about giving maintenance dosages and this kind of thing. They do feel that some further experimentation in this regard could legitimately be done under appropriate standards and medical supervision. In fact, there is in New York such an experiment going on now with the full knowledge and consent of the Narcotics Bureau.

Mr. SENNER. This is in California?

Mr. KATZENBACH. No; in New York. There may be others, but I know of one in New York.

Mr. SENNER. You say that your bill, that is, the administration bill, is broader in scope than the Celler bill. As I understood from the chairman of the committee, one of the provisions of his bill, not included in your bill. was an additional appropriation to persuade State governments to look at the problem and to participate with the Federal Government in finding a just solution to this problem. Would you comment why you feel the administration bill is broader in scope than the Celler bill?

Mr. KATZENBACH. The administration bill is broader in scope in one important respect, that is, those who are eligible for civil commitment. Mr. Celler confines it to those who have been convicted of narcotics offenses. We have found, as I said in my statement, 44 percent of the addicts were convicted of offenses which had no relationship to the narcotics laws. We would make them eligible. They are still addicts and we would make them eligible for treatment. So, it is broader in that regard.

As far as the provisions of his bill with respect to encouraging States to take steps in this regard, HEW tells me they presently believe they have sufficient authority under existing law with respect to hospitals, medical programs, research programs, and so forth, to cover the same area that is covered in his bill. I am sure they can testify more fully with respect to those bills than I can, but it is their view that while they do not oppose those provisions, they are unnecessary.

Mr. SENNER. Thank you, Mr. Attorney General, for your straightforward and excellent responses to the questions.

Mr. KATZENBACH. Thank you.

Mr. ASHMORE. Mr. Hungate.

Mr. HUNGATE. I join in the remarks of my colleague, I would like to inquire, Mr. Attorney General, concerning the California experience. Did that apply to people who had violated the law involving narcotics, or had they violated other laws?

Mr. KATZENBACH. I believe it applied to people who violated other laws as well.

Mr. HUNGATE. It was not restricted solely to narcotics offenders?

Mr. KATZENBACH. So I understand.

Mr. HUNGATE. This bill on page 3 discusses eligible individuals, and excludes those charged with crimes of violence.

Mr. KATZENBACH. Yes.

Mr. HUNGATE. They are defined in another section, 101(c). I wonder what was the thinking in excluding such individuals.

Mr. KATZENBACH. The thinking was that these people are particularly dangerous and they have offended society in a particularly serious way with a crime of violence. They, of course, would be eligible for treatment following conviction.

Mr. HUNGATE. They would be eligible up to 10 years; is that right?

Mr. KATZENBACH. That is right. We are trying to draw a line here, Mr. Congressman. We feel that the approach of strict punishment with respect to narcotics offenders has been successful. We do not want to abandon that approach. It is not something to make everything easier for criminals, whether they are addicts or not. We also feel that addiction is such a problem in our society that we ought to try to treat it and do something about it. So, the bill tries to run a line between those objectives.

There is some incompatibility, but we try to run a line between them. This is one of the compromises.

Mr. HUNGATE. In defining crimes of violence, they include burglary and housebreaking. I wonder if they customarily would be considered crimes of violence.

Mr. KATZENBACH. They are broadly defined.

Mr. HUNGATE. This would also exclude anyone, would it, with a conviction of an offense punishable by imprisonment for more than 1 year? Do I understand that correctly? Crimes of violence include assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for more than 1 year.

Mr. KATZENBACH. Assault with a dangerous weapon.

Mr. HUNGATE. Or——

Mr. KATZENBACH (continuing). Assault. It is an assault charge.

Mr. HUNGATE. Would this relate to offenses under State laws?

Mr. KATZENBACH. Yes.

Mr. HUNGATE. They would be included?

Mr. KATZENBACH. In this section, they would not be included. They would be included where it talks about conviction of prior felonies; yes.

Mr. HUNGATE. I believe that is all. Thank you.

Mr. GRIDER. I have no questions, Mr. Chairman. I would like to thank the Attorney General for his appearance and his statement.

Mr. KATZENBACH. Thank you, Congressman.

Mr. ASHMORE. General, let me ask you one other question. Am I correct that the Federal Government has no jurisdiction over a narcotic addict when he has committed no Federal crime? Therefore, no Federal crime is committed.

Mr. KATZENBACH. That is correct.

Mr. ASHMORE. In other words, a person possessing narcotics has not committed a Federal crime.

Mr. KATZENBACH. Possession itself is not a Federal crime, but possession itself is presumptive of an intent to sell or to use.

Mr. ASHMORE. You mean merely possessing, if he had a pound of morphine or heroin, he would not be violating any Federal law unless they could prove he had it to sell?

Mr. KATZENBACH. I think if he had that amount, the presumption would be pretty persuasive.

Mr. ASHMORE. I was trying to determine: The simple fact of possessing it is not a violation of the law, is that right?

Mr. KATZENBACH. That is correct, Mr. Chairman.

Mr. ASHMORE. Why is that true?

Mr. KATZENBACH. Because that is the way the law is written. That is the best answer I can give.

Mr. ASHMORE. Why is it not an offense to possess it? The possession of contraband whisky is an offense, without the tax being paid on it.

Mr. SENNER. Is it not due to the fact that there are legal uses for narcotics as distinguished from illegal uses?

Mr. KATZENBACH. It is largely related to the problem of Federal jurisdiction. We have to show that it is untaxed, for example, that it is imported, transported across State lines, something that gives us a Federal basis for prosecution. Possession raises the presumption.

Mr. ASHMORE. What percentage are convicted of possession? Have you many cases where you try people on no evidence other than that they possess narcotics?

Mr. KATZENBACH. Usually we have more evidence than that, so we can show something about the person, other admissible evidence, evidence of sales. The Narcotics Bureau, through undercover agents or otherwise, tries to get a person in the act of selling.

Mr. ASHMORE. Then the indictment would merely say possessing for the purpose or intent of resale.

Mr. KATZENBACH. Yes, or untaxed, no stamp.

Mr. ASHMORE. Do you agree or what is your opinion with reference to Mr. Celler's provision for the appropriation of $15 million for research purposes in this field?

Mr. KATZENBACH. I believe, Mr. Chairman, that really should be more appropriately addressed to HEW, who would conduct the program. I am not trying to duck it. They tell me they have money for research. I am interested in economies just as I know the chairman is.

Mr. ASHMORE. We have heard testimony with reference to the narcotics law and its effectiveness and results in Great Britain. Is their more liberal program proving more successful or not, in your opinion?

Mr. KATZENBACH. In my opinion, it has run into considerable difficulties, particularly recently. There has been evidence of increasing addiction in Great Britain. It has been so in the United States, also. If you compare the two radically different programs, I would say ours has been successful with more addicts, and theirs has been successful but there are more addicts. Neither has come even close to eliminating the problem. I do not think the English program, however, we evaluate it, would be a particularly suitable program for the United States. Even the English who support their program as being forward-looking and intelligent, right, and so forth, acknowledge the differences, the social, sociological differences in Great Britain with a rather homogeneous population and strong traditions, less mobile, less moving around. Their program in many respects may be related to that and might not be at all suited to the United States.

Mr. ASHMORE. Do you think it would work in this country?

Mr. KATZENBACH. I do not. I feel quite strongly it would not.

Mr. ASHMORE. This particular phase of it.

Mr. KATZENBACH. Yes.

Mr. ASHMORE. One provision of the regulation permits doctors, if I understood Mr. Celler correctly, to prescribe narcotics more liberally and without more justification. Would that work here?

Mr. KATZENBACH. I do not believe so. I think the treatment you give people for their addiction, as I said before, generally involves removing the drug, not giving it. That seems to be the view of most medical authorities on the subject, not precluding further experimentation along that line.

Mr. MCCLORY. I think the significant distinction between our systems of trying to eradicate drug addition and that in Britain is that in Britain they permit the registration of drug addicts and they permit the registered drug addict to receive the drug legitimately in order to carry on his addiction while they try to cure him. It does result in an attempt to keep tabs on the drug addict with the idea that while he continues it he may be cured through the individual practitioner. That approach has been recommended to a great many States, but I do not think it has been adopted in any State, to my knowledge.

Mr. KATZENBACH. No, it has not, Congressman. Attractive as it sounds, the difficulty is that it keeps an addict going, rather than trying to get rid of it.

Mr. ASHMORE. Can you come back at 2 o'clock, Mr. Attorney General?

Mr. KATZENBACH. Yes.

Mr. ASHMORE. We have a quorum call. I think we had better adjourn until 2 o'clock. Also, the representatives from Treasury and the Department of Health, Education, and Welfare will be back at 2, please.

(Whereupon, at 12:45 p.m., the subcommittee adjourned, to reconvene at 2 p.m., of the same day.)

AFTERNOON SESSION

Mr. ASHMORE. We will come to order and proceed with the Attorney General, Mr. Katzenbach.

Mr. KING. General, on page 4 of your bill, the administration bill, line 19, at the end of it it says the court may advise him. Speaking of an eligible individual as an addict, the court may?

Mr. KATZENBACH. Yes, sir.

Mr. KING. What is the criteria?

Mr. KATZENBACH. My recollection, Congressman, is that in the court's judgment they believe that this person is a good subject for cure.

Mr. KING. I notice you use the word "may" instead of "must."

Mr. KATZENBACH. Yes, sir.

Mr. KING. It is incumbent upon them to advise him this cure is available to him or this type of commitment is available to him? It is still in the form of may rather than must or should. I am just wondering why the choice of the word "may."

Mr. KATZENBACH. You said on page 4?

Mr. KING. Yes, page 4, line 19, section 102(a). It reads if the district court believes that an eligible individual is an addict, the court may advise him.

Mr. KATZENBACH. I think the main reason for the use of the word "may" rather than "must" was if the record did not show that the court had done this and he was then subsequently convicted, then perhaps he could urge this as—if it were mandatory language—urge this as grounds for reversal of that decision and remand in order to give him the opportunity to ask for that.

Mr. KING. Then you want to make it purely optional with the court?

Mr. KATZENBACH. I think it should be, Congressman. After all, the defendant is going to have counsel available and presumably counsel have studied the laws and considered this possibility.

Mr. KING. There is no provision in here for defense counsel to make a motion that his client be given this treatment or the option to accept this treatment, is there?

Mr. KATZENBACH. No, there is no specific provision that he can so move. But he certainly can. There is nothing that would prevent him.

Mr. KING. Nothing in here that requires the consent of the U.S. district attorney?

Mr. KATZENBACH. No, there is not.

Mr. KING. Do you not think that would be wise? Or why did you not provide for it, let me put it that way.

Mr. KATZENBACH. I think the decision should be left to the judge. We were saying that these people, they are addicts, all of them be eligible at the outset. Then if they want it they ask for it and then there has to be a study to determine——

Mr. KING. This does not say they asked for it. It says the court may advise him. If the court does not advise, he does not know anything about it?

Mr. KATZENBACH. He has a lawyer, Congressman. He is there and can advise him on it. If the court does not, he can move for it.

Mr. KING. It says at the first appearance. Very frequently at his first appearance he is not represented by counsel, is he?

Mr. KATZENBACH. This is his first appearance before the district court, not his first appearance before a commissioner or an arraignment or something of that kind. In his first appearance before the district court he would have counsel, yes. He would have——

Mr. KING. Although an arraignment and his lawyer is not there?

Mr. KATZENBACH. The arraignment almost always is before a commissioner. Rarely before a district judge except in one district.

Mr. KING. How is it in the District of Columbia?

Mr. KATZENBACH. The arraignment is normally before the Commissioner.

Mr. KING. Here in the District?

Mr. KATZENBACH. Yes, sir.

Mr. KING. You spoke this morning, I though you mentioned something about a waiver by counsel. Do you envision that?

Mr. KATZENBACH. Yes, I would envision if he requested this treatment I would think he would make that explicit waiver as to anything with respect to being tried, well advised of the prosecution to insist on that.

Mr. KING. The bill does not provide for it?

Mr. KATZENBACH. No, the bill does not have to provide for it. It does not provide for it explicitly and there is no reason why it should.

Mr. KING. What kind of election are you to have, an election in writing by the defendant himself? I can see these fellows coming back in subsequent proceedings. You know how they buck confinement.

Mr. KATZENBACH. I can see them doing that, Congressman, if we do not take the appropriate steps.

Mr. KING. You think this would cover it?

Mr. KATZENBACH. I believe so and I think it would be inadequate if there was something shown in the court record waived there.

Mr. KING. Is this treatment available to a defendant after trial?

Mr. KATZENBACH. Yes, sir. After he is convicted.

Mr. KING. After conviction?

Mr. KATZENBACH. Yes, sir; it is.

Mr. KING. That would be a first offender, would it not?

Mr. KATZENBACH. The same group that is eligible before is eligible after conviction.

Mr. KING. Even though they may be multiple offenders?

Mr. KATZENBACH. Under title 2 they are not eligible for the provisions here in title 2 if they have been convicted of two felonies apart from the trial they just have been convicted in. Two prior felony convictions, they would not be eligible. They could still get treatment because we presently provide treatment but they would not get the provisions of this act.

Mr. KING. You say you offer these people a choice. The choice is either standing trial and taking his chances, or going straight to jail. To go straight to jail is to go to a place where he might receive treatment, but, where, he will, however, be under a jail-like security—as Mr. Celler indicated—for a period of time up to 3 years?

Mr. KATZENBACH. Yes.

Mr. KING. That is not much of a choice, is it? Either go to jail or go to a hospital where you are going to be under guard all the time?

Mr. KATZENBACH. Well, I think it is something of a choice. You think you are not going to be convicted of the crime. That raises a problem there. You have always got the possibility of acquittal on the trial. The sentence you might get for the crime might be substantially greater than the 3 years provision here. You would have a——

Mr. KING. It might be a lot less?

Mr. KATZENBACH. You would have a criminal record.

Mr. KING. Have you ever thought of having them held guilty in the first place like you do under the usual law and having a provision where that record could be expunged if he goes through certain treatment?

Mr. KATZENBACH. Yes.

Mr. KING. You have thought of that?

Mr. KATZENBACH. Yes; we did.

We preferred this approach to it. The major reason for it was that in the opinion of some of the experts on this, it is believed that if you could get a person voluntarily to take this kind of a treatment, even though you hold the possibility of future trial over his head, that that

is one step toward his rehabilitation. It is an added incentive. After he has pleaded guilty, after the record is already made, you are not really holding anything over his head but the possibility of the conviction being expunged from the record.

He has gone through all of the trial, all of the conviction and in a way he has gone through some of the worst of it.

Mr. ASHMORE. Would the gentleman yield?

General, is not the California law to the effect that you are not committed unless you have plead guilty, no commitment——

Mr. KATZENBACH. That is correct.

Mr. ASHMORE (continuing). In the trial?

Mr. KATZENBACH. Yes; that is California law.

Mr. ASHMORE. That is one of the successful things or more successful than any other law we know of?

Mr. KATZENBACH. There is only one other to compare it with.

Mr. ASHMORE. You have the Federal law. Have you made a special study or sufficient study of the California law to be convinced that it is better to have this on a voluntary basis rather than a trial and plead?

Mr. KATZENBACH. That was the conclusion that we came to within the various agencies here. I believe we are right but it is a matter of judgment and opinion. The California law was enacted to do it after conviction. The New York Legislature with the California law in front of it, nonetheless decided to use the same process that we are using here.

Mr. ASHMORE. The California law goes on and expunges this conviction from the record, I understand, if he has rehabilitation possibilities?

Mr. KATZENBACH. Suspend sentence. It suspends sentence and then civilly commits him after conviction. The judge suspends any sentence and then it goes to a civil commitment procedure.

Mr. ASHMORE. After he is rehabilitated and released, then it expunges the conviction?

Mr. KATZENBACH. At the discretion of the court in which the addict was convicted the original charge may be dismissed.

Mr. ASHMORE. I do not want it to appear that I thought he should have that record stand against him if he were rehabilitated.

Mr. KING. General, I am wondering, to, about your provision on page 5, line 13, 5-day provision. Do you think that is long enough in which the defendant should make his election?

Mr. KATZENBACH. We believe it will be sufficient in most cases.

Mr. KING. Sometimes he does not have a lawyer for 5 days?

Mr. KATZENBACH. It is 5 days after his appearance. He ought to have a lawyer by then under the Criminal Justice Act.

Mr. KING. Sometimes you arraign and enter a plea of not guilty for him and then get a lawyer, or have you changed that?

Mr. KATZENBACH. This again I repeat: In his appearance before the district court he would have a lawyer. I cannot defend 5 days as against 10 days but we think it should be a short period of time.

Mr. KING. I agree it should be as short as possible.

Mr. ASHMORE. It is a certainty that he would be clear of that in 5, the effects of narcotics?

Mr. KATZENBACH. He would be suffering the aftereffects of having no narcotics.

Mr. ASHMORE. I was thinking, would he not in such a short time as that have a better opportunity to claim he did not know what he was doing under the influence of a narcotic and voluntarily agreed to go in 3 days?

Mr. KATZENBACH. No; I think——

Mr. ASHMORE. Probably it would be better to say a minimum of days must elapse before he is permitted to state whether or not he voluntarily accepted that?

Mr. KATZENBACH. I would not mind making it a period of days after he has counsel or something of that kind. Counsel should have been assigned earlier than this first appearance in court. We are trying to do the same, accomplish the same thing by talking of appearance. You can add a proviso he must have had counsel available to him for a certain period of time.

If you want to say he could take no less than 5 days or more than 10 or something like that it would be all right. I do not think the effects of the narcotics would really be a particularly persuasive reason for doing that.

Mr. ASHMORE. He would be provided counsel under the act we passed?

Mr. KATZENBACH. Yes, sir.

Mr. SENNER. Mr. Chairman, if you yield, I think if we look at page 5, line 13, it permits an individual to have more than 5 days. It is on line 15. He has the 5 days to make an election except on showing at a time of the election the individual shall be barred from election and hearing. I assume if there was good cause he could make a showing why in 5 days he didn't make it?

Mr. KATZENBACH. Yes; that is right.

Mr. HUNGATE. Would the gentleman yield?

Mr. ASHMORE. Mr. King has the time.

Mr. KING. I have only one more question here and then I will yield to my colleague, Mr. Chairman.

In speaking of the crime that might be committed by an addict. I want to get this clear in my mind: Let us assume that the crime on committed by the addict has no relation to the use of narcotics. That is, the user of narcotics. Is he still entitled to this relief if he is discovered to be an addict?

Mr. KATZENBACH. Yes, he would be, Congressman, but it is difficult to conceive, if he is an addict, of the assumption that he made that the crime had no relationship whatsoever to it.

Mr. KING. You think only addicts commit crimes in order to get money to buy narcotics?

Mr. KATZENBACH. No, no; I think the effect of the narcotics may be a factor in any crime they commit.

Mr. KING. Well, that is a moot question. Just one more question.

Mr. KATZENBACH. They do not behave normally. Very few people behave normally when under the influence of narcotics.

Mr. KING. I have seen them on arraignment where they were users and they were pretty sharp. I have seen them within 4 or 5 days thereafter when they had the shakes and going through withdrawal.

They would plead to anything or consent to anything in order to get out or get someplace where somebody would give them a shot to take them out of their misery. That is what I am thinking about. They will do almost anything to get relief.

Mr. KATZENBACH. That is one of the reasons for having this longer period of time for examination here by the Surgeon General.

Mr. KING. Thank you very much.

Mr. ASHMORE. Mr. Hutchinson?

Mr. HUTCHINSON. Can you tell us, Mr. Attorney General, what the capacity is at those institutions at Fort Worth and Lexington? You said that they were not filled to capacity. How many patients can they handle, do you know?

Mr. KATZENBACH. I do not know exactly. I think it is in the neighborhood of 1,000 to 1,500. I am not sure.

Mr. HUTCHINSON. What percent of capacity are they filled to generally?

Mr. KATZENBACH. Lexington has been much fuller, I understand, than Fort Worth. The Fort Worth institution has been——

Mr. HUTCHINSON. Quite a number of years ago——

Mr. KATZENBACH. It has been used for a variety of other purposes because it was not filled with narcotic addicts.

Mr. HUTCHINSON. I am advised that the Surgeon General's Office is going to appear and they can probably answer these questions since those institutions are under their control and not yours.

Mr. KATZENBACH. That is correct. I am sure that the Surgeon General can provide you those figures.

Mr. HUTCHINSON. Then I have no further questions.

Mr. ASHMORE. I do not want to cut you off for a quorum call.

Mr. MCCLORY. I have a few questions, Mr. Chairman, if it is all right.

Mr. ASHMORE. All right.

Mr. MCCLORY. General, I want to ask you this: Is not the administration bill sort of adopting the program which New York and California have initiated? I thing this is making it a Federal program for Federal cases?

Mr. KATZENBACH. Very similar to both the California and New York programs.

Mr. MCCLORY. What I am wondering then is this: Since those programs are both relatively new and they do not have too much experience as far as the adequacy of the program is concerned although early results are promising, I am wondering if it would not be sufficient for the present to have merely grant authority for the Attorney General and the Surgeon General to turn over cases of this type to the State authorities for treatment under their programs?

Mr. KATZENBACH. We do this to some extent under this bill because at least in your aftercare programs in States like California, which has a functioning system, you could probably contract with the State authorities there to take your Federal people in California.

Mr. MCCLORY. At the same time, is it not a fact with regard to the rest of the Nation you may be duplicating a program which may develop into something wonderful and then may be abandoned?

Mr. KATZENBACH. We are not really duplicating it. In the first place we have facilities to treat these people when they are in Federal custody. They are going to be in Federal custody anyhow. We are going to have to be doing something with them if they are guilty of these crimes. They are going to be in our custody and our supervision, anyhow. These people it seems to me should be given the benefits of this program.

The second point that I would urge is that I would like to have all of the facilities of the Surgeon General's Office and the facilities of the experimentation and observation and study that has been done through the Surgeon General's Office available to study this.

I think those facilities are superior to any others in the country.

Mr. MCCLORY. There are similar type programs with regard to alcoholism, sex deviates, and other areas of criminal and psychiatric conditions?

Mr. KATZENBACH. Yes, sir.

Mr. MCCLORY. Where this type of modern approach is being recommended and carried out through State legislation. As a matter of fact, would it not be preferable to grant to the Federal Government the authority to permit utilization of these State programs and their facilities with regard to narcotics addicts, alcoholism, sex deviation, and these other extraordinary things?

Mr. KATZENBACH. We have a particular Federal interest in the narcotics because of our responsibilities in that area which go beyond alcoholism and some of the more normal State crimes. Again all I can do, Congressman, is to say, we have the facilities and resources to do this. At least as far as the institutional care is concerned. We can do that at Lexington and Fort Worth. When it comes to the aftercare, it is contemplated that it would be contracted out and if there are existing State facilities for that, as there would be in California, I think the Surgeon General would use them.

Mr. ASHMORE. Gentlemen, we have to recess to answer a rollcall. As far as I know that will complete your testimony, Mr. Attorney General, unless you want to summarize when we get back.

Mr. KATZENBACH. No, thank you, Mr. Chairman. That is all I have.

Mr. KING. There are some statistics we would like to have. Can we phone or write you to have your office submit them?

Mr. KATZENBACH. Yes, sir.

Mr. KING. Numbers of cases and so forth?

Mr. KATZENBACH. Be happy to, Mr. Congressman.

(Short recess taken.)

Mr. ASHMORE. We shall proceed to hear Mr. James Pomeroy Hendrick, Acting Assistant Secretary, Treasury Department.

Do you have anyone here with you, Mr. Hendrick?

Mr. HENDRICK. Mr. Chairman, since there has been so much brought out this morning by the two witnesses, would you care to have me summarize rather than read my statement?

Mr. ASHMORE. I think it would be fine if you did summarize it, Mr. Hendrick. Then we can put your entire statement in the record.

Mr. HENDRICK. Thank you, sir.

STATEMENT OF JAMES P. HENDRICK, ACTING ASSISTANT SECRETARY OF THE TREASURY

Mr. HENDRICK. My name is James P. Hendrick. I am Acting Assistant Secretary of the Treasury. My office supervises, on behalf of the Secretary of the Treasury, the activities of the Bureau of Narcotics as well as the Bureau of Customs.

I appear to support the administration bill, H.R. 9167.

As has been pointed out by others, H.R. 9167 is the result of very careful study by Treasury, Justice, and HEW. It is a carefully drafted bill and Treasury fully supports it.

There were two other bills, H.R. 9159 and H.R. 9249, introduced by Congressmen Ottinger and Krebs, which are to the same effect as the administration bill. All the others are in line with H.R. 9051, as to which Congressman Celler testified this morning.

We see advantages in the administration bill. It is broader in that 9051 allows civil commitment to narcotics violators only, whereas the administration bill admits civil commitment for numerous other types of crime.

It is narrower in that the administration bill excludes crimes of violence. Its drafting, we think, is superior, particularly with reference to allowing as eligible offenders those who are sellers of narcotics who sell in order to support their addiction. We believe that that is a better way to handle this problem than to use the term in 9051, which is sale for resale.

Of course, we do not insist on the exact wording of our bill as against any other.

I would like to put into the record a detailed comparison item by item of these two bills.

Mr. ASHMORE. That may be inserted together with your complete statement after you conclude your summary.

Mr. HENDRICK. A substantial amount of Treasury's work deals with law enforcement. We have the Secret Service, Bureau of Customs, Coast Guard, Internal Revenue, and, of course, we have the Bureau of Narcotics.

We operate in the narcotics field under six major narcotic statutes. Two of these relate primarily to possession, two to sale, two to smuggling.

In connection with my description of these bills, let me say I am using laymen's terms. Actually possession of narcotics is not in and of itself a crime. What is a crime is to have narcotics in your possession which you have purchased, or which you sell without having paid the necessary tax, or without evidence that you have done so. Possession gives rise to a presumption that you have these narcotics without having paid a tax. That is why I say that these two laws relate to possession. Actually, to be very technical, they relate to purchase or sale.

The penalty for these statutes is, in the case of the possession laws, a minimum of 2 years; in the case of the sale or smuggling a minimum of 5 years.

Mr. ASHMORE. Can those sentences be suspended or must it be confinement?

Mr. HENDRICK. As to the possession laws, yes, they can be, but as to the sale and the smuggling laws there may be no suspended sentence and no probation, and as of now there is no eligibility for parole.

Youths under 22, and I am talking about the present laws, may be eligible for special treatment under the Youth Corrections Act.

These are tough penalties, but we feel they are justifiably tough. Since the penalties have been put into effect the record of enforcement has been substantially better. It is known that at the famous and notorious Appalachian meeting there was considerable discussion as to whether the gangs should discontinue entirely dealing with narcotics, particularly groups that were there at the Appalachian meeting.

Valachi has testified that the word went out, some time later on, that all families were notified "No narcotics." That, of course, was a reference to the Cosa Nostra.

Having said that we are in favor of stiff penalties, we do not, of course, say that penalties are the entire solution of the problem. We have quotations here in this statement from former Secretary of the Treasury Dillon and from the President that there are other things we should do than continue solely with a penal approach.

The administration bill which is before us accomplishes essentially two things. One, it mitigates the mandatory penalties in respect of sale and smuggling, and this will apply primarily to nonaddicts. It mitigates them, first, by extending the application of the Youth Correction Act from under the age of 22 to under the age of 26; second, it provides that marihuana offenders may be eligible for parole.

The second part of the bill, which is, of course, by far the more important, is the hospital commitment procedure. You have heard a full description of that by the other witnesses, and I am sure you will hear more detail on that from the Surgeon General.

There are just one or two things that appeal to us particularly about this civil commitment procedure. One is the 5-day period for electing to come under the civil commitment procedure.

Mr. ASHMORE. Is that a long enough period in your opinion?

Mr. HENDRICK. It could be 5 or it could be 10 days, but the great advantage of this is that it takes the addict off the streets. It has been suggested that an addict ought to have some time between the time that he is arrested and the time that he recovers from the shock of it. The trouble is that an addict, all the time that he is out in the clear, he is taking dope. The great advantage of this bill—the great advantage of a speedy choice as to whether there should be commitment is that it takes the addict off the streets.

Another thing we like about the bill is that it separates the bad actors from those who are eligible, who appear to be eligible, for rehabilitation. In addition to that we like this procedure of allowing special treatment and commitment for the addict who can show that the sale of narcotics was to support his addiction.

That is a summary of the statement that I have to make and I reiterate that the Treasury Department fully supports this legislation.

(Mr. Hendrick's statement follows:)

STATEMENT OF JAMES P. HENDRICK, ACTING ASSISTANT SECRETARY OF THE TREASURY

My name is James P. Hendrick. I am Acting Assistant Secretary of the Treasury. My office suprvises, on behalf of the Secretary of the Treasury, the activities of the Bureau of Narcotics as well as the Bureau of Customs.

My purpose in appearing before this subcommittee is to outline the Treasury Department's position in support of the proposed Narcotic Addict Rehabilitation Act of 1965, contained in H.R. 9167 which was recently introduced by Congressman Celler at the request of the administration.

THE BILL

H.R. 9167 puts in writing an up-to-date compilation of the views of this administration, under general policy guidance of the President, taking into consideration recommendations of many experts in this field over the past years, and benefiting from months of careful study and drafting by the Departments of Treasury, Justice, and Health, Education, and Welfare. The Treasury Department fully supports this bill.

COMPARISON WITH SIMILAR BILLS

Other bills prepared along the same general lines are also before your subcommittee. I would like, with your permission, Mr. Chairman, to submit a comparison of the administration bill, H.R. 9167, with a typical representative of the other bills—H.R. 9051. This comparison lists the principal features—which, in general, are quite similar in all these other bills—showing the differences in treatment. As far as the Treasury Department is concerned, the provisions of H.R. 9167 are far preferable. We are not prepared to support these other bills.

TREASURY'S LAW ENFORCEMENT WORK

A substantial proportion of Treasury's work deals with law enforcement. Its Secret Service has responsibility for safeguarding the President and the Vice President, and protecting the American people against counterfeiting of our money. Its Bureau of Customs is concerned with smuggling across our borders. Its Coast Guard enforces a variety of laws related to the security of our ports and the safety of our waters. Its Internal Revenue Service enforces the income tax laws and, as a part of this task, seeks out those who would avoid paying their just share of the Nation's financial burden.

The work of Treasury's Bureau of Narcotics is of particular interest to this subcommittee today, since the Bureau is the official enforcement arm of the Federal Government in suppressing the illicit narcotic drug traffic and, as such, wages unremitting war on the narcotics traffic at both national and international levels. Also of interest is the work of Treasury's Bureau of Customs, whose responsibilities in connection with prevention of smuggling notably include making every effort to prevent the illegal entry of narcotic drugs into this country by land, sea, or air.

SUMMARY OF THE SIX MAJOR NARCOTIC STATUTES

Six statutes form the basic tools with which these two Bureaus carry on their work.

Two of these relate primarily to possession: 26 U.S.C. 4704, dealing with the possession of narcotics on which the required tax has not been paid: and 26 U.S.C. 4744, dealing with the possession of marihuana on which the required tax has not been paid.

Two others relate to sale: 26 U.S.C. 4705, dealing with the sale of narcotics without the required special order form; and 26 U.S.C. 4742, dealing with the sale of marihuana without the required form.

The last two relate to smuggling: 21 U.S.C. 174, dealing with the unlawful importation of narcotics; and 21 U.S.C. 176a, dealing with the unlawful importation of marihuana.

THE MANDATORY PENALTIES

The penalties provided in these statutes and in 26 U.S.C. 7237 (a) and (b) can, in general, be summarized as follows:

For the two "possession" statutes: First offense, minimum 2 years, maximum 10 years; and second offense, minimum 5 years, maximum 20 years.

For the other four statutes involving the more serious offenses of "sale" and "smuggling," the penalties are: First offense, minimum 5 years, maximum 20 years; and second offense, minimum 10 years, maximum 40 years.

The minimum of 10 years and maximum of 40 years is also the prescribed penalty for third offenses in the "possession" statutes.

The four statutes dealing with "sale" and "smuggling" provide a special penalty in cases of sales to children under 18. It is not less than 10 years with a maximum of 40 years or even death if heroin is the drug sold, notwitstanding that the case is a first offense. I should add in passing that the death penalty has never been imposed.

The four statutes dealing with "sale" and "smuggling" provide that there may be no suspended sentence or probation or eligibility for parole. The same is true with respect to second (and subsequent) offenders under the two "possession" laws. Youths under the age of 22 may be dealt with more leniently, however, even for these offenses, by being sentenced under the Federal Youth Corrections Act.

Admittedly, the mandatory penalties are tough. The Treasury Department believes they should continue to be tough. Parenthetically, at this point, I should note that those who criticize these penalties frequently overlook the fact that the time served may be reduced by about one-third for good behavior.

The mandatory penalty provisions have been a vital factor in helping to cope with the illicit traffic in narcotics. We are certain that the narcotic addiction problems in this country would be much greater had it not been for the deterrent effect of these provisions and, of course, the unrelenting effort of the Bureau of Narcotics and the Bureau of Customs in seeking out and obtaining evidence which has led to the conviction of hundreds of major narcotics traffickers. Among these have been many in the higher echelons of organized crime. Mandatory penalties and rigorous enforcement have proven effective in removing the more persistent violators from their illegal activities for long periods of time, and in deterring others who might otherwise have followed in their footsteps.

PENALTIES ARE NOT THE ENTIRE SOLUTION

At the same time, however, the Treasury Department would be the last to suggest that strict penalties represent the entire solution to the problem. As the then Secretary of the Treasury, the Honorable Douglas Dillon, stated in September 1962 at the opening session of the White House Conference on Narcotic and Drug Abuse:

"The Treasury Department and its Bureau of Narcotics do not favor the penitentiary confinement of addicts in preference to treatment and possible cure. We have never had such a policy."

Thus, the Treasury Department agreed, in principle, with the 1963 recommendation of the President's Advisory Commission on Narcotic and Drug Abuse that the mandatory penalty provisions of the Federal narcotics and marihuana laws should be applied restrictively in such a way as to provide a greater incentive for rehabilitation. This position is in line with the views which President Johnson expressed to the Congress on March 8, 1965, in his message on crime, when he said:

"The return of narcotic and marihuana users to useful, productive lives is of obvious benefit to them and to society at large. But at the same time, it is essential to assure adequate protection of the general public."

THE BILL—LIMITED MITIGATION OF CERTAIN PENALTIES

The proposed Narcotic Addict Rehabilitation Act of 1965 accordingly provides for a change in two essential respects. First, the minimum penalties are mitigated in that drug offenders under 26 (instead of, as heretofore, under 22) would be eligible for indeterminate sentence and conditional release under the Federal Youth Corrections Act for rehabilitative treatment. In addition, in recognition of the fact that marihuana is nonaddictive and that its users are, therefore, generally more amicable to rehabilitation, marihuana offenders would be allowed to become eligible for parole. Only in these two cases is mitigation of mandatory penalties provided for nonaddicts.

THE BILL—HOSPITAL COMMITMENT

Second, and more important, the proposed legislation would provide a hospital commitment procedure applicable to addicts who appear likely subjects for rehabilitation whereby, if their past record and their behavior during hospitalization justify it, all penalties may in due course be waived and any criminal record expunged.

The details of how the commitment procedure can be effected in the case of addicts charged with Federal offenses, and of how hospitalization and subsequent conditional release can be given those already convicted of a Federal offense, have been fully explained in testimony heretofore given to the subcommittee.

TREASURY DEPARTMENT'S APPRAISAL

From the enforcement standpoint the Treasury Department is particularly interested in two safeguards wisely incorporated into the provisions for commitment. First, under civil commitment the addict is immediately removed from circulation, in contrast to the present situation under which he may remain free on the streets continuing for months or even years to indulge his habit and committing crimes to support his addiction, while out on bail awaiting trial. Second, every effort has been made in the drafting of the bill to separate the sheep from the goats. Persons charged with crimes of violence or who are under pending charges of felonies are not eligible for commitment, nor are those who have previously been twice committed. If the charge is sale of narcotics, the defendant is not eligible for commitment unless he convinces the court that the sale was made to support his addiction.

Insofar as mandatory penalties are otherwise mitigated in the case of nonaddicts, the mitigation is properly limited, we believe, to those who should have the best chance of being restored to useful life: namely, the young, and those who have dealt with marihuana rather than the more deadly narcotic drug.

Viewed more generally, the proposed legislation may be said to adopt a new approach to the treatment of an addict in terms of mental illness rather than crime. With this the Treasury Department is in full accord.

Wisely administered, particularly with respect to aftercare of addicts released from confinement, the legislation can represent a significant forward step in this thoroughly perplexing and troublesome field. We urge that it be approved.

Annex to statement

Comparison of H.R. 9051 and H.R. 9167

[H.R. 9051 by Mr. Celler is a Kennedy-Javits-type bill; H.R. 9167 by Mr. Celler is identical to the administration bill]

Feature	H.R. 9051	H.R. 9167
A. Civil commitment in lieu of prosecution for offense charged.	Has extensive provisions.	Has extensive provisions.
1. Eligible addicts	Only addicts charged with an offense relating to narcotics.	Addicts charged with any offense against the United States.
2. Excluded addicts	(1) Addicts charged with any offense except a narcotics violation, and (2) any addict charged with selling for resale.	(1) Addicts charged with crime of violence. (2) Addicts charged with selling narcotics, unless found that sale caused by his addiction. (3) When there is a felony charge or on parole. (4) When addict has 2 previous felony convictions. (5) 2 prior commitments under act or under any State proceedings. (6) Persons not suitable for rehabilitation.
3. Maximum time to elect commitment in lieu of prosecution.	10 days.	5 days.
4. Release on bail after election made	Not permitted.	Not permitted.
5. Who determines addiction?	U.S. Surgeon General.	The court upon report from U.S. Surgeon General.
6. Initiating proceedings	Proceedings begin before "a committing magistrate." After that, it is not clear which "court" has jurisdiction.	Before U.S. district court.
7. Time for making examination	Within 10 days after election and placing in custody of Surgeon General.	30 days, but may be extended additional 30 days.
8. Hearing on Surgeon General's report	Findings may be contested in court.	No hearing on adverse report.
9. Period of civil commitment	Indeterminate period not to exceed 36 months.	Indeterminate period not to exceed 36 months.
10. Custody of addicts	Surgeon General at all times.	For examination court may direct either the Attorney General or the Surgeon General to take custody. For treatment, the Surgeon General has complete custody.
11. Disposition of criminal charges	Held in abeyance during tests and treatment, subject to being reinstated if not suitable for program.	Same.
12. Termination of institutional civil commitment and conditional release.	Determination by Surgeon General that person has been cured of addiction; or after expiration of 36 months.	Determination by Surgeon General that person has made sufficient progress.
13. Resumption of pending criminal proceeding	Determination by Surgeon General that person cannot be treated as a medical problem; or person returns to drugs or refuses Surgeon General directive while conditionally released.	Determination by Surgeon General that person cannot be treated as medical problem; or after 24 months the court may order resumption of prosecution if Surgeon General cannot certify progress in treatment; or after expiration of 36 months; or return of the person to use of narcotics while conditionally released.
14. Period of conditional release	Court may set a 24-month probation period after Surgeon General certifies person is cured or has been treated for 36 months.	Institutional and aftercare treatment may not exceed 36 months.

Annex to statement—Continued

Comparison of H.R. 9051 and H.R. 9167—Continued

[H.R. 9051 by Mr. Celler is a Kennedy-Javits-type bill; H.R. 9167 by Mr. Celler is identical to the administration bill]

Feature	H.R. 9051	H.R. 9167
A. Civil commitment—Continued		
15. Returning person to institutional care during period of condition release.	No specific procedure or authority mentioned. Presumably Surgeon General may so provide under his authority to promulgate aftercare regulations.	Surgeon General has full authority to require return of probationer for treatment. Surgeon General has authority to examine for drug use.
16. Credit for commitment period	If charges are reinstated, time spent in program credited toward service of sentence received.	Credit only for time spent in institutional custody.
17. Commitment not a criminal offense	Civil commitment is not considered a criminal offense, and results may not be used in any criminal action.	Same, except fact that person is an addict may be elicited at trial as bearing on credibility.
18. Contracting State agencies to provide treatment, aftercare, etc.	Permitted	Permitted.
19. Delegation of functions by Surgeon General	No such provisions	May delegate performance of functions.
B. Commitment after conviction	Limited provisions	Extensive provisions similar to civil commitment.
1. Persons eligible	Narcotic addicts and any person suffering from a mental or physical condition.	Narcotic addicts with the exceptions noted below.
2. Excluded persons	None	Same as A.2. above.
3. Examination to determine ailment	No special provision	Court may direct Attorney General to make determination.
4. Initiation of proceedings	Court may order commitment for treatment and rehabilitation at time of sentence. Also, Attorney General may direct the action to be taken.	Court may commit custody of person to Attorney General for examination and report to court. Then, court may place in custody of Attorney General for treatment under program.
5. Length of commitment	No special provision	10-year limit and no longer than maximum sentence which could have been imposed under the violated statute.
6. Conditional release	No specific provision	Person must be confined for treatment for 6 months before release under supervision.
7. Supervision in the community	Parole Board is authorized to enter into agreements to provide for supervisory aftercare.	Offender under jurisdiction of Parole Board. Attorney General may contract for supervisory aftercare. Board has absolute authority to revoke conditional release.
8. Special handling by Attorney General of persons convicted who are addicts or suffering mental or physical condition.	Authorizes Attorney General to designate place of confinement in any suitable institution and to transfer freely from 1 place to another.	No specific provision. However, the Attorney General now has this authority. He sends addicts to the PHS hospitals and other sick prisoners to Springfield.

C. Grant-in-aid	Extensive provisions	None specifically provided.
1. To assist in construction of hospital-type institutions for treatment of "drug users."	$15,000,000 for 1st year and $15,000,000 for next 2 years. Grants are not to exceed ⅔ of cost of construction.	None.
2. To assist in establishing, developing and maintaining programs for treatment of "drug users."	$7,500,000 for 1st year and $7,500,000 for the next 2 years. Grants not to exceed ¾ cost of States' program.	Do.
3. Advisory Committee on drug abuse	Secretary of HEW to appoint 9 members to do liaison work with States, advise Secretary in carrying out grants.	Do.
4. Definition of drug abuser	Includes all persons who use any narcotic or any other drug which may cause psychotoxic effects which are apt to result in disability.	None specifically provided.
D. Penalty changes	Extensive	Limited.
1. Marihuana smuggling	Eliminates minimum mandatory sentences. Eliminates the restriction against giving suspended sentence and probation.	Makes all marihuana violators eligible for parole, but retains all minimum mandatory sentences and restrictions on suspended sentence and probation.
2. Internal Revenue Code violations. (Secs. 4704, 4705, 4742, 4744).	Except for selling narcotics to person under 18, eliminates all minimum mandatory sentences for sellers and 2d offenders of possession. Reduces penalty from 10 to 5 years for selling narcotics to minor.	Same as above.
3. Suspended sentence and probation	Eliminates all restrictions, except selling heroin to person under 18, or for smuggling or receiving smuggled narcotics. Permits suspended sentence for any offense of selling except selling heroin to person under 18.	No change.
4. Parole	Eliminates all restriction except, (1) persons sentenced for smuggling or receiving narcotics and persons convicted of selling narcotics to minors (under 18) are not eligible until after serving not less than the minimum penalty which could have been imposed, and (2) persons receiving life imprisonment would be eligible after serving 15 years.	Only change is to permit parole to all marihuana violators including sellers and subsequent offenders.
F. Extension of Federal Youth Corrections Act	Made available to all offenders up to the age of 26. It appears that the suspension of sentence and probation provisions of FYCA would not be available to those who are otherwise not eligible due to offense of selling to persons under 18, or for smuggling or receiving smuggled narcotics.	Includes all violators up to age 26, but specifically excludes suspension of sentence and probation features of FYCA if offense calls for minimum mandatory sentence.

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Mr. ASHMORE. Mr. Hendrick, I believe it was the Celler bill which recommended that all enforcement be removed from Treasury and placed under the Attorney General. Do you people have any particular difficulty with enforcement? Do you want to get rid of it? Do you want to retain it? What is your thinking on that?

Mr. HENDRICK. I don't believe, sir, that is part of the Celler bill, although the Congressman did testify that he was in favor of such transfer.

Mr. ASHMORE. Maybe that was in the Commission report.

Mr. HENDRICK. That is a recommendation of the President's Commission. It is a recommendation which as far as I know has had no support anywhere in the Government. I was very pleased to hear the Attorney General make complimentary remarks about the Bureau of Narcotics, and quite obviously if the change were made it would have to be an overall change.

If you read the report of the President's Commission on that, the Commission recommends that all the basic legislation be changed so that narcotics offenses are placed not on the basis of a fraud on the revenue but are based, rather, on the commerce clause. It would be quite an undertaking to get all these changes through.

We feel that the Bureau of Narcotics is doing an excellent job, and when you have a winning team you just don't want to change the players.

Mr. ASHMORE. You work now under the present law with the Attorney General, do you not, in the law enforcement?

Mr. HENDRICK. Of course, which is true of our other enforcement agencies, also.

Mr. ASHMORE. In these bills if we should adopt the civil commitment procedure, at what point would the defendant or would the accused or would the addict be released from your supervision and turned over to the Attorney General?

Mr. HENDRICK. As a matter of fact, sir, we never have supervision over the defendant.

Mr. ASHMORE. You make the case and when it gets to a later stage the Attorney General handles it?

Mr. HENDRICK. We help the Attorney General to make a case.

Mr. ASHMORE. So you do not now have any supervisory control, or control of any kind, over the man who has been held, convicted, tried, or is being treated?

Mr. HENDRICK. That is right.

Mr. ASHMORE. That is entirely under the supervision of the Attorney General?

Mr. HENDRICK. That is right, or, as it may be, under the supervision of the Surgeon General if this law passes.

Mr. SHATTUCK. Mr. Hendrick, in the discussion of the administration bill there was reference to the exclusion area provisions and a definition as to who would be eligible for this type of civil commitment. On the other hand the Celler bill perhaps does not have the precise exclusions which the adminstration bill has.

Has there been thought as to the question of just what the effect would be, in your study is there anything with regard to the effect of exclusion of certain persons by reasons of the limitations in the definition of "eligible individual" in section 101(g) of H.R. 9167? I am

thinking in these terms. Many of these people have been in trouble with the law before and they have criminal records. Yet, perhaps when they are picked up on this particular offense they would, but for these provisions—that is, prior conviction of a felony offense, that type of thing—be excluded from treatment.

Does this mean somebody who might have been helped by this provision is barred?

Mr. HENDRICK. We feel that our provisions in that respect are broader than those in H.R. 9051. We exclude because of prior conviction only if the man has been guilty of two felonies, which is a pretty good indication that there is not too much hope for him, but we do include, which 9051 does not, people who are charged with crimes other than narcotic crimes.

We have found out that people who are addicts do not make their money only by selling dope. They have to make a lot of money, let us face it. It may cost an addict, or he may have to get, some $50,000 a year to support his addiction. He has to get the money from some source or other. Addicts are people almost always in the lower economic class. They don't have the income, nor, being addicts, do they have the earning power, so what they do is to try to get money one way or the other.

There are a number of different Federal crimes other than narcotic violations which would permit violators to be eligible for civil commitment. Among these are: theft from mail (except by burglary or robbery); theft of Government property (except by burglary or robbery); theft from interstate commerce shipment; forging a Government security; White Slave Act; tax revenue laws such as liquor and firearms; and all offenses on Government reservations and in the District of Columbia.

Those are just examples, but that is a way in which the administration bill is considerably broader in this respect than the other one.

Mr. SHATTUCK. Yes. I believe the Attorney General commented on the same point.

Mr. HENDRICK. That is right.

Mr. SHATTUCK. In the exclusion section, subparagraph 3, there is this language:

> An individual against whom there is pending a prior charge of a felony which has not been finally determined.

As to that point, this means a charge which may be pending in a State jurisdiction?

Mr. HENDRICK. Yes.

Mr. SHATTUCK. Or a Federal?

Mr. HENDRICK. That is right.

Mr. SHATTUCK. Do you have any comments on that? It would seem this is a charge which has not been determined in any way and yet is sufficient to bar one from the benefits of this act.

Mr. HENDRICK. That is something which has been studied and it seemed to folks who studied the legislation that we ought to be that tough. The fact that a person has been already charged with a felony indicated he was a bad actor. That is just a matter of judgment, of course.

Mr. SHATTUCK. It would be assumed this man perhaps would be out on bail?

Mr. HENDRICK. That is right.

Mr. SHATTUCK. After having been charged?

Mr. HENDRICK. Yes.

Mr. ASHMORE. Did you mean a moment ago that the average addict expends $50,000 a year for narcotics?

Mr. HENDRICK. Actually he doesn't expend more than around $10,000 a year, but if he gets that money illegally it is largely in connection with stealing, and when he steals he sells to a fence and he sells to a fence for one-fifth of the value of the goods.

Mr. ASHMORE. You mean, then, that it takes $10,000 worth of dope to keep a man at his normal state, in the state he desires to be, for the 12 months?

Mr. HENDRICK. That is a figure which I have heard quoted.

I can give you one more figure if you would care to have it.

Mr. ASHMORE. Yes.

Mr. HENDRICK. Based on an estimate of 60,000 addicts spending about $15 a day on narcotics, we estimate in the neighborhood of $350 million expended annually at the consumer level.

Mr. ASHMORE. They are all crime breeders necessarily, then, are they not?

Mr. HENDRICK. Yes.

Mr. ASHMORE. Crime producers multiplied. They must be in order to satisfy their own desires.

Mr. HENDRICK. Yes, sir.

Mr. ASHMORE. I imagine you hear from them only when they get into trouble. How about the rich man, who has income enough to purchase all he needs? I imagine you don't hear from him.

Mr. HENDRICK. That is right.

Mr. ASHMORE. Mr. Grider?

Mr. GRIDER. The Attorney General testified that of all of the inmates of Federal prisons who were addicts that 43 percent of them were there for crimes not related to narcotics.

Can you tell me what percentage of those nonnarcotic law violators have committed crimes of violence?

Mr. HENDRICK. I have no figure on that.

Mr. GRIDER. It would seem to me that the percentage must be fairly high. Stealing is one of the things that addicts do, of course, but——

Mr. HENDRICK. Having said that, sir, I must point out that the usual addict—and 90 percent of our addicts are heroin addicts—the usual addict is a fairly peaceful man. He is rather a gentle soul. Addiction with heroin does not make you ordinarily a violent man. It makes you gentle.

Mr. GRIDER. You might resort to burglarly or housebreaking in order to get funds.

Mr. HENDRICK. That is right, there is the irresistible impulse to get this heroin, but typically it is done in a rather gentle rather than a brutal fashion if the addict can get the money that way.

Mr. GRIDER. A lot of these gentle ways can still lead to violence.

Mr. HENDRICK. It could be.

Mr. GRIDER. And those people are not eligible for this free commitment program?

Mr. HENDRICK. No, sir.

Mr. GRIDER. That is all, Mr. Chairman.

Mr. ASHMORE. You say 90 percent of the drug addicts use heroin?

Mr. HENDRICK. That is right.

Mr. ASHMORE. Heroin is a form of morphine?

Mr. HENDRICK. It is a more refined form of morphine. It comes from opium. The opium then is converted into a morphine base, and the morphine base then is treated chemically. The treatment is quite simple. The average amateur chemist can do it. It requires no special equipment, no special knowledge of chemical science. It thus becomes heroin.

Mr. ASHMORE. Opium is the base?

Mr. HENDRICK. That is right, sir.

Mr. ASHMORE. All of that comes from the Orient?

Mr. HENDRICK. Some comes from the Orient. Some comes from the Near East. Those are the two principal sources.

Mr. ASHMORE. None is actually produced in this country?

Mr. HENDRICK. None produced in this country; no, sir.

Mr. ASHMORE. What about poppy?

Mr. HENDRICK. It is from a particular kind of poppy.

Mr. ASHMORE. Opium comes from a poppy plant?

Mr. HENDRICK. That is right.

Mr. ASHMORE. The poppy is just the plant?

Mr. HENDRICK. That is right.

Mr. ASHMORE. Marihuana is not habit-forming?

Mr. HENDRICK. That is right, sir.

Mr. ASHMORE. And that is the reason this bill, and that is the reason you recommend a different penalty and an altogether different procedure for treatment for a man who has violated the law with regard to marihuana?

Mr. HENDRICK. The only recommendation that the bill has as to marihuana is to make the mandatory penalties less stiff for the marihuana user in that he would be allowed parole.

Under the smuggling and sales of narcotics laws they are not allowed parole.

Mr. ASHMORE. They are classified and characterized the same as heroin dealer or user?

Mr. HENDRICK. That is right.

Mr. ASHMORE. This proposed bill would lessen the penalty there.

Mr. HENDRICK. To the extent that parole would be permitted.

Mr. ASHMORE. Do we produce marihuana here?

Mr. HENDRICK. Almost none. It is produced in substantial quantities in Mexico. It could be produced here because it is something that can be grown almost anywhere.

Our enforcement on that is very good and as far as I know we have no known places in the United States where marihuana is grown.

Mr. ASHMORE. Mr. McClory?

Mr. MCCLORY. Thank you.

Mr. Hendrick, I want to try to clarify this. Earlier today we discussed the subject of the possession of narcotics and whether or not that was an offense in itself. I would gather from the summary of the statement of the law you have set forth here that ordinarily the possession of narcotics would be an offense because ordinarily you would not be discovering narcotic addicts, or a person dealing in narcotics, with narcotics upon which the tax has been paid. Is that correct?

Mr. HENDRICK. That is exactly it. Technically the law does not say that possession is an offense.

Mr. MCCLORY. With respect to the offender who is apprehended with narcotics in his possession, who would be covered under this legislation, can you conceive of any such offender doing otherwise than electing to take the treatment in lieu of standing trial? The penalty that the Congress has imposed, especially on second offense, a minimum of 5 years, it is inconceivable that any second offender who was apprehended with narcotics in his possession would do other than to take the 3-year cure. Is that right?

Mr. HENDRICK. That would not disturb us at all if he was eligible because we feel that this civil commitment procedure, when applied to eligible addicts, gives the best hope for restoring them to a useful life.

Mr. MCCLORY. Unless he has been guilty of some crime of violence, two felonies, or something like that.

Mr. HENDRICK. That is right.

Mr. MCCLORY. If he were just a pure dealer in narcotics the chances are he would be eligible; is that right?

Mr. HENDRICK. Of course, if he were a pure dealer in narcotics then he would have to prove that any sale he made was to support his addiction rather than for profit. However, if you take the dealer in narcotics who is found with some narcotics in his possession we cannot accuse him of being a dealer until we find that he has sold.

Mr. MCCLORY. That is right; so that every person who is arrested with narcotics in his possession and against whom you cannot make a case as far as a sale, he will elect the 3-year cure rather than the 5-year penalty.

Mr. HENDRICK. That would be true as to the second offenders. If it is a first offender then he can get away with 2 years.

Mr. MCCLORY. He could get 10 years.

Mr. HENDRICK. He could.

Mr. MCCLORY. Whereas under the other he could not get more than 3.

Mr. HENDRICK. That is right.

Mr. MCCLORY. Do you have any fears so far as this reduction of the penalty is concerned in cases of that type?

Mr. HENDRICK. No fears at all, sir; because if the test as to whether he is rehabilitable is well carried through, the Surgeon General or the court will not allow commitment as to the addict who is not a good risk for restoration to a useful life, whereas the addict who is a good risk will be allowed the civil commitment and there then will be some chance that he can be restored to useful life instead of being merely incarcerated for a longer period of years and then very likely return to his addiction or to crime when restored, or when let out of prison.

Mr. MCCLORY. You have no familiarity with addiction from other substances—goof balls, barbiturates, and things of that nature. They are not covered in the law which governs your office?

Mr. HENDRICK. Those are covered under a separate law which is the responsibility of the Surgeon General.

Mr. MCCLORY. I think that is all, Mr. Chairman.

Mr. ASHMORE. Am I correct in saying that the dealer in narcotics who is working for a profit and is not an addict is not eligible for the civil commitment?

Mr. HENDRICK. That is right; unless he is one of these under 26, in which case he can get the benefits of the Youth Corrections Act.

Mr. ASHMORE. You use that age because we hope there is a good chance to rehabilitate him.

Mr. HENDRICK. That is exactly it.

Mr. HOFFMANN. How many Federal narcotics cases on the average have you investigated in the last 3 years?

Mr. HENDRICK. I have a table here which shows narcotic and marihuana violators reported by the Federal Bureau of Narcotics. Do you want it for 3 years?

Mr. HOFFMANN. About how many cases are we talking about per year?

Mr. HENDRICK. In 1962 it was 1,678. In 1963 it was 1,814. In 1964 it was 1,945. Those are broken down as between narcotics and marihuana. Narcotics is by far the larger.

Mr. HOFFMANN. These figures just show the man involved in a narcotics offense, not the addict involved in some other kind of crime. Is that correct?

Mr. HENDRICK. That is right.

Mr. HOFFMANN. Do you have a breakdown of the figures to show how many of those cases are in the District of Columbia?

Mr. HENDRICK. No. I can give you the number of addicts we have in the District of Columbia if that would be of any use to you.

Mr. HOFFMANN. If you do not think it is over the frightening point.

Mr. HENDRICK. 1,076.

Mr. HOFFMANN. I wonder if you could comment on the guidelines that you have for the Treasury agents and the cases they investigate as opposed to the cases which, for instance in the District of Columbia, the Metropolitan Police would investigate, or which the State authorities would investigate in the case of New York.

Mr. HENDRICK. In general, the Bureau of Narcotics gets after the bigtime traffickers. Our agents do their very best to ferret out the people they think are the really important ones. Indeed they have been very successful in that respect.

As far as the Bureau of Customs is concerned, on the other hand, they get every case which crosses a border which is necessarily a Bureau of Customs case rather than a State case.

Mr. HOFFMANN. In New York, for instance, when we talk about the man who is just selling enough narcotics to take care of his own habit, are we not talking about an area which is predominantly of State jurisdiction?

Mr. HENDRICK. It could be, except every once in a while you will find somebody who is an important trafficker who gets involved. I would say in the main the small-time person will be more caught by the State officer than the Federal officer. That does not mean, however, if the Federal officer finds a case he will not proceed with it.

Mr. HOFFMANN. I have a question now with regard to your opening comment, specifically as to the procedure to be followed under section 102(a) of H.R. 9159. You said in your judgment the advantage of this legislation was the speed with which the addict was taken off the street. I assume you would be agreeable to a modification of this legislation which would allow a U.S. commissioner to make this initial determination. I am speaking only from my own knowledge, which

is of the practice in the District of Columbia. After the man is arrested he is first brought before a U.S. commissioner, where his bond is set and—under a new law—a lawyer is appointed for him. Then he is freed on bond pending the action of the grand jury. I do not know what the average figure in the District is, but this man would not be arraigned in the District court until an approximate minimum of 3 weeks to a month after his arrest. Did you anticipate this?

Mr. HENDRICK. Quite frankly, that is something that I have not thought of. The way you express it to me now, it seems quite reasonable to make a provision along the lines you suggest so as to get the addict off the street as soon as possible. I say that with some hestitation because these matters are very technical, and it might be that the experts working on it would have some objection.

Mr. HOFFMANN. Your concern and your interest in this is to have the addict taken off the street as speedily as possible from the time of his initial apprehension.

Mr. HENDRICK. Yes, because as long as he is free, he will be indulging his addiction. Not only that, but an addict somehow or other always wants to get more people addicted. It is a sort of contagious dissease, and there is something strange about his psychological makeup that makes him want to have other people be addicts, too. So, the more addicts we can take off the street, the better off we are.

Mr. HOFFMANN. Just a couple more questions, if I may.

In reading the District of Columbia cases, and I think other circuits indicate the same problem, there is a classic pattern where an undercover agent is working in an area and it is required that his identity be kept secret for the period of his investigation, which may be in some cases upward of several months. The U.S. attorney's office locally has a lot of trouble if the investigation lasts too long because of the impact of the speedy trial and due process aspects which become involved whenever you prolong bringing a man to justice after commission of an offense. Would you see any danger in Congress enacting legislation such as this from a policy point of view that would inhibit your ability to carry on a long-term undercover operation? In other words, the only reason we suggest not bringing the people to trial immediately is because of the public necessity to continue these effective long-term operations. Are we not, by passing this act encouraging getting the man off the street, diluting the public interest in having the long-term operation on which your Department depends for effectiveness in many cases?

Mr. HENDRICK. I would say we would be very glad to consider any such proposal. I point out, however, that under the civil commitment procedure, once the person agrees to a civil commitment, then he goes in right away.

Mr. HOFFMANN. I am referring now to whittling away the time in which we can legally continue an investigation after perfecting a case; in other words, the length of time you continue before you compromise your undercover agent.

Mr. HENDRICK. We certainly would be very willing to consider any such proposal.

Mr. HOFFMANN. One final question. In the administration bill there are a number of legal technical problems raised with the procedures under title I which could very easily be cured by just having title

II and no title I. In other words, have a plea of guilty or a finding of guilty prior to the man's being committed for treatment. Of course, we would look to the speed which you think is a happy advantage of this legislation. Have you given any thought to doing away with title I in favor of the more crisp remedy which would suggest to the man that he is wrong in the first instance in having committed a crime, before he goes off to civil commitment.

Mr. HENDRICK. We certainly have given a great deal of thought to that. This bill went through a number of stages of drafting. We finally concluded that it was better to have the two separate, and you pointed out the main reason for that. It is the matter of speed in getting a person in custody. Even if we had a procedure for allowing a plea of guilty subject to being expunged later on, there are delays in getting the case before the court even to that extent. The court may not be in session for a number of weeks or months. There are all sorts of delays. Those are the reasons we thought it better drafted the way it is.

Mr. SHATTUCK. Mr. Hendrick, Mr. Celler proposed the abolition of minimum sentences. This is a provision that is in several of the bills pending before the Congress in both the House and the Senate. I would be glad to get your views on this aspect of the bill, not the administration bill, I realize, but the Celler bill—H.R. 9051.

Mr. HENDRICK. We are very definitely in favor of continuing the minimum sentences in respect of nonaddict offenders with the mitigation which we are willing to have made which is contained in the administration bill; namely, parole for marihuana offenders, and also extending the Youth Correction Act to people under 26. Quite simply, the reason is that from the time these penalties were put into effect, our record of enforcement has been far better, and there have been many people who, as I pointed out, among the big traffickers, have stopped any business in connection with narcotics. During the period that these strict sentences have been in effect, the price of heroin has gone up very substantially. As a result, the heroin itself has been cut more and more when sold on the black market, with a beneficial result to the addict, indeed, because the addict now, instead of getting a fairly pure heroin, which he did in the past, now gets a very much diluted version, and when it comes to withdrawal of an addict, instead of the classical symptoms which you see in the movies and described in the old books on the subject, whereby the poor addict, particularly if he is given the cold turkey treatment of withdrawal without any assistance from narcotics in the meantime, just temporarily goes crazy and suffers terrible pain. Nowadays, however, the withdrawal can be accomplished in a few days time, probably at most 2 or 3 weeks, with little or no discomfort.

Mr. SHATTUCK. Do you feel this is directly attributable to the minimum sentence?

Mr. HENDRICK. That is the way we feel.

Mr. SHATTUCK. The committee received a communication from the Judicial Conference of the District of Columbia which states:

> *Be it resolved*, That it is the sense of this Conference that the mandatory minimum sentence now provided in the Federal narcotics law be repealed.

Apparently they do not agree with you on that. They probably feel it inhibits their ability to deal with the individual cases which come before them.

Mr. HENDRICK. Of course, the judges do not agree with us because they like to be independent. Everybody likes to be independent. The fact is that the Congress of the United States in 1951 and then in 1956 unanimously enacted the tough penalties. I am sure the judges did not like that at the time, but the result was very favorable in respect of controlling addiction.

Mr. SHATTUCK. You think that has an effect on controlling addiction, but, of course, there are other rather serious Federal crimes in which the minimum provision may not be such an element, is that correct?

Mr. HENDRICK. Let us face it. In the Treasury Department we are interested in only a limited number of crimes. Narcotics is one of them. If we see something which is done by way of legislation which helps us, we are not going to try to stop it.

Mr. SHATTUCK. Therefore, you would go only so far as the administration bill does?

Mr. HENDRICK. That is right, in terms of the marihuana and people under 26.

Mr. SHATTUCK. Thank you very much, Mr. Hendrick.

Mr. ASHMORE. Thank you very much, Mr. Hendrick. We appreciate your views on this matter.

We will now hear from Dr. Terry, the Surgeon General.

STATEMENT OF DR. LUTHER L. TERRY, SURGEON GENERAL, PUBLIC HEALTH SERVICE; ACCOMPANIED BY DR. STANLEY F. YOLLES, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; AND DR. G. P. FERRAZZANO, CHIEF, DIVISION OF HOSPITALS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. TERRY. Mr. Chairman and members of the committee, I am accompanied by two members of my staff. On my immediate left is Assistant Surgeon General Stanley Yolles. Dr. Yolles is the Director of the National Institute of Mental Health. On my right is Assistant Surgean General Gabriel Ferrazzano, who is the Chief of our Division of Hospitals, under which the two hospitals at Lexington and Fort Worth operate.

Mr. ASHMORE. Suppose you go into that. I never have understood. Are they different types of institutions? Do you treat people in a different manner, or what is the distinction?

Dr. TERRY. Basically, the two hospitals are similarly directed. Both are hospitals confined to the care of neuropsychiatric patients with emphasis on patients who are narcotic addicts. On the other hand, at the Lexington Hospital we have our larger research laboratories which are working on this problem of narcotic addiction, which makes it slightly different from the Forth Worth Hospital.

In addition, at Fort Worth since World War II, we accept patients from the Department of Defense and the Veterans' Administration. At the present time there are a significant number of neuropsychiatric patients in the Fort Worth hospital who are not drug addicts, who are there under contract with the Veterans' Administration.

The hospital at Lexington is devoted almost entirely to narcotic addicts.

Mr. ASHMORE. Earlier today a witness stated that Federal institutions were not being used to their fullest capacity; in other words, that there might be room for more people than they now have if they were sent there. What is the situation in that regard?

Dr. TERRY. Mr. Chairman, it was Mr. Katzenbach who made that statement, and in certain respects he was correct and in other respects he was not.

For instance, our constructed bed capacity at the Fort Worth hospital is 775 beds, whereas last year our average daily patient census was 778, or 3 more patients on the average, running a little above 100 percent occupancy. At the same time, I would point out that of these 778 patients during 1964, 354 were addicts and 424 were nonaddicts. In other words, slightly more than half the patients at Fort Worth during that year were neuropsychiatric patients who were not addicts.

On the other hand, with regard to Lexington, the constructed bed capacity of Lexington is 994 beds; and during 1964 we had an average daily patient load of 1,035, or about 100 more patients than the facility was constructed to accommodate. Of those 1,035 patients, 940 were addicts, and only 95 were nonaddict neuropsychiatric patients.

So, from the standpoint of utilization of the beds, we are utilizing them to an almost phenomenal degree inasmuch as we in essence are running at 100 percent capacity, and this is above the initial constructed capacity at all times. This is made possible by the fact that so many of the patients stay for fairly long periods of time and, therefore, with a slow turnover, one can in effect utilize all of the beds that you have put up.

Mr. MCCLORY. I want to ask if you put two or three addicts in one bed.

Dr. TERRY. No, sir.

Mr. ASHMORE. They put them in the hallways, I suppose.

Dr. TERRY. As a matter of fact, I gave the constructed capacity at Lexington. The number of beds we have put up at Lexington is 1,042, with an average daily patient load of 1,035. So, we do not have more than one patient to a bed in either facility.

Mr. ASHMORE. You may proceed, Dr. Terry, in whatever manner you wish.

Dr. TERRY. Mr. Chairman, I have a moderately lengthy statement here. However, since so much of the questions around the proposed legislation relate to the medical aspects, if I may, I would like to present my entire statement to you.

Mr. Chairman and members of the committee, this is a welcome opportunity for the Department of Health, Education, and Welfare to join with the Federal law enforcement agencies in recommending to the Congress measures to deal more effectively with the evils of narcotic addiction. President Johnson stated, in a directive to all Federal agencies concerned, on July 15, 1964:

> I desire the full power of the Federal Government to be brought to bear upon three objectives: (1) the destruction of the illegal traffic in drugs, (2) the prevention of drug abuse, and (3) the cure and rehabilitation of victims of this traffic.

In my presentation today, I should like to deal mainly with the essential features of the legislation before this committee, specifically in relation to the President's second and third objectives, but bearing

in mind that accomplishing each of these objectives will serve indirectly to accomplish the other.

I am here today in support of H.R. 9167, introduced on behalf of the administration by the distinguished chairman of the House Judiciary Committee, Mr. Celler.

I believe that the programs it propose for the treatment and rehabilitation of narcotic addicts are compassionate and constructive. They recognize that addiction is both a health problem and a law enforcement problem. And, insofar as it is a matter of medical concern, this legislation recognizes that it is both a physiological and psychosocial problem.

Chairman Celler has also introduced H.R. 9051 which likewise makes provision for such programs of treatment and rehabilitation, as do a number of other bills now before this committee.

The large area of common ground between these various proposals indicates, I believe, a growing consensus both as to the necessity for new legislation in this field and as to the general approach to the basic problems involved.

That general approach, embodied in the administration legislation, is to strike the necessary balance outlined by the President in his March 8 message to the Congress, on "Crime, Its Prevalence, and Measures of Prevention," between the obviously beneficial return of addicts to useful, productive lives and the clear essentiality of assuring adequate protection to the general public.

That drug abuse does represent serious evils from the point of view of both public health and law enforcement requires little in the way of further documentation.

There is, perhaps, less general understanding of the nature of the evils of drug abuse. The popular, sensationalized picture of the dope fiend is a distortion of the truth. Criminals may be drug abusers, and may even become true addicts. Certain drugs are stimulants and may be conducive to violence in individuals predisposed to violence. But narcotic addicts especially, and those who use other drugs with similar sedative effects, are most often associated with nonviolent crimes, such as shoplifting, forgery, and prostitution, rather than with violent crime.

While the specific effects of the various drugs that are commonly subject to abuse vary with the nature of the drug, the individual who uses them, and the circumstances of their use, in their various ways they lead to disability and compulsive behavior in the individual who abuses them and to his alienation from normal society. Nonetheless, drug abuse is usually a symptom of some other underlying disorder, rather than the original cause of an addict's disabilities and alienation. The drug abuse itself requires treatment, but to achieve any lasting correction we must also relieve the underlying disorders that make people become drug abusers and addicts.

Mr. ASHMORE. Do more people become addicts from hospitalization and treatment?

Dr. TERRY. This happens, Mr. Chairman, but I would say it is relatively rare and very rarely poses any serious problem. I do not know whether Dr. Yolles would have anymore to comment on that.

Dr. YOLLES. Only to say, Mr. Chairman, that this was a phenomenon a number of years ago when some practitioners of medicine were

not aware of the dangers of addiction. It has decreased markedly as we see at the Lexington and Fort Worth hospitals. Today, as the Surgeon General says, it represents a very small percentage of cases.

Mr. ASHMORE. Why is there a growing percentage of people who become addicts? Are they persuaded by drug addicts to take it, or are they criminally inclined and do not have enough courage to do what they ought to do and take the drug to boost their courage, or what?

Dr. YOLLES. Mr. Chairman, I do not think we are really aware of all the reasons why people become addicted, nor do we have any proof of the fact that there is an increasing number of persons addicted to narcotics. You may be referring to the fact that there are increasing numbers of persons who are using other drugs as well, such as the barbiturates, the amphetamines, and some of the newer drugs coming out.

Mr. ASHMORE. I had in mind mostly the narcotics. Is there an increase in the number?

Dr. YOLLES. It is very difficult to estimate, and I am sure the Bureau of Narcotics would agree with me that while they have been doing a magnificent job in collecting figures on addictions in the United States, their figures are not complete. They do not represent those persons known to medical facilities, and because of medical confidentiality, those persons and their names and the numbers of them are not available to the Bureau of Narcotics at the present time.

So we really do not have complete statistics. One of the great needs in the field today is to have adequate studies in this field, of the number of addicts in the country.

Mr. ASHMORE. Proceed, Doctor.

Dr. TERRY. The first essential feature of H.R. 9167 is the provision in title I which allows for rehabilitative treatments under civil commitment in lieu of trial and imprisonment for certain narcotic addicts who are alleged to have committed Federal offenses.

Treatment and rehabilitation would be available, under H.R. 9167 and the other bills before this committee, for eligible addicts who, before trial, elect to be considered for civil commitment.

There are, however, some major differences between the civil commitment provisions of the administration bill and those, for example, of H.R. 9051. While both bills contain provisions designed to exclude commercial peddlers, H.R. 9051 is applicable only to persons charged with violating a Federal narcotics law. The administration bill applies more broadly to addicts who violate other Federal laws. Addicts are often arrested for forgery and other crimes against property, which they commit in order to buy narcotics. The addict who is apprehended for the forgery of a Government check, is no less in need of medical help than he would be if he were arrested for a narcotic offense. I would strongly urge the committee to follow the approach taken by the administration bill in this regard.

On the other hand, the administration bill is more exclusive in several respects: it excludes anyone who is charged with a crime of violence, anyone who has two or more previous felony convictions, and anyone who has been civilly committed for narcotic addiction on two or more occasions. These are limitations adopted in the interest of public safety, and in recognition of the still novel and somewhat uncharted nature of this kind of program.

Both H.R. 9167 and H.R. 9051 provide that when an individual elects to be considered for civil commitment, he would be examined by the Public Health Service to determine whether he is in fact a narcotic addict. Under H.R. 9167, the examination would also extend to whether he is a good prospect for rehabilitation if he is treated. This is an important difference. The administration bill frankly and consistently treats the eligible addict as a medical problem, once he has elected to seek civil commitment. I think that the fuller medical and psychological evaluation contemplated by H.R. 9167 is essential to the success of such a program. Under H.R. 9167 the Surgeon General would report the results of his examination to the court and make a recomemndation as to whether the individual should be civilly committed. If the court, after considering the report and any other evidence, committed the addict to the Surgeon General for treatment, the criminal charge would be held in abeyance to await the outcome of the treatment.

Mr. ASHMORE. What about the proceeding at this point? The Surgeon General reports the results of his examination. How will you get all your people to determine the decision? Where do you have offices in the country? How would you get these addicts from Seattle, Wash., for example? It comes up in court and is referred to you to make a determination. How would that be done?

Dr. TERRY. Generally speaking, with the extended type of examination which we would carry out on these individuals; namely, a study through 30 days, which could by law be extended for an additional 30 days, we would have sufficient time to transport this individual to one of our facilities where we now have specialized services.

Mr. ASHMORE. That would have to be done at——

Dr. TERRY. Lexington or Fort Worth. On the other hand, Mr. Chairman, I think one should appreciate that this bill also provides that the Surgeon General may contract for services from other medical organizations or conceivably could use other installations of the Public Health Service for such determination.

Mr. ASHMORE. Would you use State institutions?

Dr. TERRY. We could use State or private.

Mr. ASHMORE. It would depend on the ability, equipment, and personnel of the institutions you might have, I suppose.

Dr. TERRY. We could also use our other installations, provided we had the proper personnel in terms of psychiatrists, psychologists and related types of personnel necessary to evaluate these individuals in our other Public Health Service hospitals.

At the same time, I think, quite frankly, the major thrust and at the outset I think the whole thrust would be toward moving them to our specialized facilities for such evaluation.

Mr. ASHMORE. You have just two of them?

Dr. TERRY. That is right, sir.

Mr. ASHMORE. Proceed.

Dr. TERRY. If the Surgeon General certifies to the court that the individual has successfully completed the treatment program, including both institutional treatment and aftercare in the community, the successful patient would be discharged and the criminal proceedings dismissed. On the other hand, if the Surgeon General finds that the individual cannot be successfully treated as a medical problem—at any [illegible] during the period of commitment—the court would be so advised,

and the criminal proceeding resumed. Thus, under the title I commitment program the eligible addict is treated as a sick person, with the course of treatment left to the discretion of the medical authorities, once the court has made its initial determination.

There are two other points I should like to make with reference to the differences between the bills. First, the administration bill makes release for aftercare discretionary with the Surgeon General, without a return to court following the institutional phase of the treatment. As I have just noted, the fuller evaluation of the addict allowed by the administration bill would mean that screening had already taken place. I think that the single commitment to the Surgeon General subsequent to such screening is preferable, from the medical standpoint, to the two-stage provisions of H.R. 9051 which require return to the court before aftercare can be commenced. Second, no person could be committed under the administration bill if the Surgeon General certified that adequate facilities or personnel for treatment are unavailable. This is a wise safeguard, since we are likely to be feeling our way along in the beginning stages of this program. In this connection, section 105 of H.R. 9167 gives us the necessary breadth of authority to provide, through arrangements between the Public Health Service and State, local or other public or private agencies and institutions, for the wide range of services which treatment will involve, as contemplated by section 101(d) of the bill. The more limited authority provided for this purpose in H.R. 9051, which is limited to contracts with States and their political subdivisions, would be less adequate. I urge the committee to adopt the provisions of H.R. 9167 in these two areas.

H.R. 9167 further provides, in title II, for an opportunity for narcotic addicts who are convicted of Federal offenses to be committed to the custody of the Attorney General for treatment instead of being sentenced under the penal provisions of the criminal code. Such a commitment is for an indeterminate period of up to 10 years, but not more than the maximum sentence that could otherwise have been imposed. Narcotic addicts are likewise included in the provisions of H.R. 9051 relating to treatment of Federal prisoners. The basic principle of all of these proposed programs is to utilize treatment under authoritative supervision and control, rather than punishment, for addicts who show promise of rehabilitation through treatment of their addiction and the disorders underlying their addiction.

Another essential feature common to the proposals in the administration bill, and H.R. 9051, is in the nature of the treatment program. We have learned from long experience, in the treatment of narcotic drug addicts at the Public Health Service hospitals at Lexington and Fort Worth, that institutional treatment alone will not achieve rehabilitation. At least in most cases it requires a coordinated program of institutional treatment and aftercare in the community.

To appreciate this need of both institutional treatment and aftercare in the community, it is necessary to understand that drug addiction and its underlying disorders are in the nature of a chronic disease in which supportive supervision and services are essential to prevent relapse. Patients, both prisoner and voluntary patients, have been freed from addiction and restored to apparent good health at our Lexington and Fort Worth hospitals only to relapse when they are again

exposed to the stresses of family and community life that make escape through drugs attractive to susceptible individuals. This does not mean that a hospital program is useless nor that an addict is a hopeless case. It simply means that after a hospital program has successfully done what can be done in a hospital, it is still necessary to follow the patient in his community and help him to establish himself as a self-reliant, useful citizen. The administration's proposed legislation authorizes a treatment program which will maintain continuity all the way from the time when the addict is examined before commitment, through the period of institutional treatment, and then through the period of aftercare in the community until the Surgeon General can certify that he has successfully graduated—or else he is returned to the court.

Mr. ASHMORE. Has any effort been made or experiment made of placing these people in another community or away from their former associates when they are released from the institution?

Dr. TERRY. There has been a considerable number of experiments in terms of the types of programs used, the aftercare treatment. Dr. Yolles has a considerable acquaintance in this field and I would like him to attempt to answer your direct question and comment on the other, if he may, Mr. Chairman.

Dr. YOLLES. Mr. Chairman, the experiments tried over the years in the field of drug addiction have been very many, indeed. Certainly, it appears logical if an individual becomes addicted in a community where a great deal of crime flourishes, after his hospitalization he should not be returned to that community and his former associates. This has been tried in some cases, and with very good success in a small number of cases. However, I think I should point out that the great difficulty in the treatment of narcotic addiction cases over the years has been the lack of aftercare, as the Surgeon General just said. Regardless of the community conditions which exist and which may very well give rise to crime and addiction, I am sure the committee is aware, taking New York City as an example, of the very many people who have been born and lived their early life in the lower East Side under conditions of great squalor, and there are many people who turned to a life of crime and, on the other hand, many people became successful jurists, scientists, et cetera. So the problem really rests with the individual and the individual's psychological makeup and his resistance to the local conditions. What we are attempting to do in aftercare is to support the individual, provide him with support in the community so he can resist these stresses in the community so it does not become mandatory to remove him from the community in which he was brought up and in which there may be some other support that he needs—friends, although not necessarily friends who would lead him further in the field of drug addiction.

Dr. TERRY. On the other hand, I think Dr. Yolles would agree if such an individual came from such unfavorable circumstances in his community, if he wished to locate elsewhere after his addiction was cured, so to speak, certainly we would encourage him to do so.

Dr. YOLLES. Yes.

Mr. ASHMORE. I know, of course, that even though an individual's psychological makeup has a lot to do with it—his courage, willpower, self-control, and whatnot that he might have—we had a statement to

the effect that 90 percent of those released from Lexington returned to the institution within 6 months.

Dr. TERRY. May I correct that figure. I believe those figures were based on a study at the end of 6 years of patients released; in other words, within that period of 6 years. I believe the figures for relapse, so to speak, at the end of 6 months are closer to 75 percent, but they are still very disconcerting.

Mr. ASHMORE. The California law has been in effect 3 or 4 years, and 45 percent of them come back.

Dr. TERRY. Yes, sir; around 50 percent.

Mr. ASHMORE. Forty-eight or fifty percent. Something makes that difference. Is the reason for it the aftercare, the probation, and close supervision the State of California is giving these people which you have not been able to give? It seems to me that might be the key to the thing.

Dr. TERRY. Mr. Chairman, I think the difference, insofar as we can evaluate it, is largely due to the fact that for our patients released from Lexington and Fort Worth there has been no aftercare program, which we feel is tremendously important. On the other hand, you must take into consideration, too, that many of these patients who have been in Lexington, for instance, have been voluntary patients who stayed there for short periods of time. They were able, since they were voluntary admissions, to leave the hospital at their own discretion, and against our medical advice. Certainly, the chance of that sort of person returning to addiction in the community is much higher than a patient who has had more extended and more complete study and treatment in the hospital. So, it is a combination of these two factors, probably.

I would like to emphasize the tremendous importance that we feel there is to an adequate, organized, good aftercare program.

Mr. ASHMORE. That would require a large increase in personnel by you and the other institutions which handle it.

Dr. TERRY. It would require some on our part, Mr. Chairman, but I think wherever possible we would attempt to utilize facilities and personnel existing in the communities, and in the area to do this on a designee basis or contractual basis. The bill provides that we can reimburse a person or institution for carrying out this sort of thing. Of course, we would have to choose them with great care to be sure they were capable and experienced in terms of carrying out the responsibilities of this provision, which are basically those placed upon the Public Health Service.

Mr. ASHMORE. I realize, too, that California is one State, whereas your institutions would have to care for people scattered all over the country.

Dr. TERRY. Yes, sir. Certainly, in discharging individuals from our institutions to their home in California, say, we would expect to utilize the facilities and people in California to do that for us under a contractual arrangement.

Mr. GILBERT. I am sorry I walked in late because I was at another meeting, but I was very pleased to walk in at the point where you were mentioning the fact of the aftercare treatment of the narcotic addict. I do not know if you were in the room this morning when I raised the question. This always has been of vital concern to me. The prob-

lem is, first, the fact of the treatment because it is a disease; and second, what happens after you allegedly complete a cure when they return to their home environment. It has been my experience that the vast majority of the addicts return to their environment and almost immediately are back on the drug habit.

I have had people in my congressional office, both the wife and the mother, saying, "My boy is going to be released from Lexington or is going voluntarily to quit Lexington. What can we do to keep him out of this neighborhood, because he is going back on the drug as sure as I am talking to you, Congressman."

I have had instances where addicts are committed by a State court and the mother or the parent or the wife comes in and says, "Look, there is no point in sending him to jail, because if he is to be released and comes back here, he will be in the same position. I have some friend of mine out in the Midwest who would take him where he could work."

The thought occurred to me, suppose the community out in the Midwest or wherever this individual was going caught wind of this, what would be the effect upon that boy or that individual in regard to the community?

How would they treat him? Would he be worse off? I think this is where we have to place our emphasis and our thoughts at this time because there is no question we can all determine what sort of treatment and how we should do this and gradually weed him off the drug. That is only one part of the story. I think our great emphasis has to be placed upon employment, and in setting up aftercare treatment in communities.

I do not know what the answer to this thing is. It is longer than it is broad. I am just curious, Dr. Yolles, about your reactions to these problems I have learned about directly from talking to people in my own district and I wonder if you have any thoughts upon this subject.

Dr. YOLLES. I am sure that I could not agree with you more that the aftercare rehabilitation in the community is perhaps the most important and the most difficult part of the treatment of drug addiction. I would like to point out that the Public Health Service has been aware of this factor and we have been very acutely aware of the fact that we had no authority for followup of patients in the community.

In 1957, as the second stage of development of a carefully planned study, started about 4 years before by the Lexington Hospital for the purpose of following up on the patients who were returned to New York City to determine what really happened to them, what services they were getting, how they were receiving help, and to see if they could follow the patients in New York, a 5-year followup study was started and ran through 1962. This was a study by the National Institutes of Mental Health to determine the extent and parameters, if you will, of rehabilitation in the community.

The report was published a few years ago. I have them available for the committee if you want them.

Mr. GILBERT. I would.

Dr. YOLLES. Let me summarize some of the findings. They led to the supervisory type of aftercare. The persons who made the study pointed out that treatment should be individualized. You cannot

develop a universal type of treatment. One of the most important findings was that there was a strong need to use authority to hold the addict in treatment, whatever the treatment is, and it is not solely psychiatric treatment, at least for the first 2 years, as an outpatient. Further, that the addict should be checked upon during this period of time by chemical testing to see that he has not reverted to the use of narcotics.

Another important and very significant finding was that there must be one person or agency which is responsible for all aspects of the addict rehabilitation and follow him, visit him if necessary, make contact with him and act in loco parentis for him, helping him make decisions, seeing that he gets to the agencies he is supposed to, whether vocational rehabilitation or psychotherapy, and giving him the needed supports we discussed a moment ago while helping him and his character structure or personality to withstand some of the problems in his local environment.

These are the findings which came out of this study. You may say these are fairly obvious things. There have been so many opinions in this field over the years, gentlemen, that no one knows what is quite true. We are reluctant to try any new method until we have some experimental proof for it. We do have experimental data for this.

Mr. GILBERT. Are they broken down into some categories, the cause of narcotics addiction?

Dr. YOLLES. Only very generally.

Mr. GILBERT. I am talking about psychologically, not——

Dr. YOLLES. There are a number of theories. No one of them has been satisfactorily proven, at least in my judgment. We know that it occurs in all types of emotional disturbances, mental illnesses. We know it occurs in those individuals with character disorders, those who are psychotic and those who are neurotic. It is a symptom of underlying emotional disturbance.

Mr. GILBERT. One that occurs to me very quickly is a return back to the community because whatever the psychological reason, factors in the home, has there been any study with respect to these fellows and their home environment?

Dr. YOLLES. Yes; there has. There are a good number of studies dealing with the parents of addicts, especially the mother of the addict.

I am not sure that all of the findings are equally relevant but one of the findings has been—and we put some credence in that—the type of supervision that the parents have provided, at least to this particular one of the brood, has not been of the best. These mothers particularly are described as very domineering individuals who have tried to keep the addict in a very passive role.

Mr. ASHMORE. Would this not be an area where you might utilize the Equal Opportunity Act and do something for that Great Society rather than some of the things that I understand are being hinted at? Spend some of this money to put people in the community, move them away, if necessary. Could you move people away and retrain them for jobs. What would be more important than giving this man an environment where he can control himself and make a good citizen in the future? I feel that this would provide the addict a real opportunity for rehabilitation, it would be a great chance for him under these new provisions of law we are discussing.

Mr. GILBERT. Doctor, do you actually feel that the civil commitment aspect of the bill would be a great element in the elimination of drug addiction?

Dr. TERRY. Yes, sir; it is our feeling that it would be a very important tool to have. Having these people voluntarily elect to commit themselves under this civil commitment procedure would allow controls, so to speak, over the individual for a sufficient period of time, so that you would be hopeful of a very significant degree of success. Such control would allow the individual to receive adequate institutional treatment and also get out into community.

While still under this control, he could be assisted in making the adjustment to his former community or to some other community. I think it would be very important.

Mr. GILBERT. He is going to be committed to a Federal institution or a State institution or what type of institution?

Dr. TERRY. Well, I think as you see from the proposal here, these are persons charged with Federal offenses. Therefore, they would largely, if not completely, go to Federal institutions.

Mr. GILBERT. He is released from this Federal institution and the aftercare treatment then will be elected by the State agency or voluntary agency that is under contract with the Government?

Dr. TERRY. The Surgeon General would still carry the responsibility for his aftercare. But the Surgeon General would be given authority to contract with capable institutions as outlined here, private or otherwise, to carry out the proper aftercare.

Mr. GILBERT. Is the payment made both by the private agency and the State or is it a payment that is going to be made totally by the Federal Government?

Dr. TERRY. The Public Health Service would be responsible for seeing that this care is provided. If it is available in the community without spending Federal dollars, of course, we would naturally be anxious to take advantage of that.

On the other hand, the Surgeon General would be authorized to pay for such services.

Mr. GILBERT. What do you do in the instance, Doctor, of an individual that comes from some small town in the Midwest where he might be the only one? Are you going to take care of him? Will you have some system for the care of this individual?

Dr. TERRY. Under each individual circumstance we would expect to make plans for that individual during this institutional treatment and before he actually leaves. His release from the institution would be predicated upon such an arrangement having been successfully made.

Obviously, in more remote areas it might be necessary for us to use private practitioners such as the county, city, or town health officer or some other medical person to do it. However, we would expect to arrange it in the same manner. It would be on an individual circumstance basis. At the same time, we would not expect to release an individual from the institution until adequate provisions had been set up.

Mr. GILBERT. I am very happy to hear that, Doctor. Thank you.

Mr. ASHMORE. Thank you, Doctor. Excuse us for interrupting you so much but we feel sometimes it is better to ask these questions as we go along than try to recall.

Dr. TERRY. That is quite all right. I am happy to be interrupted at the will of the committee.

As I have already noted, H.R. 9167 would give the Surgeon General a broad authorization to provide aftercare services directly and through agreements, on a reimbursable basis, with public and private agencies, for them to serve as supervisory aftercare authorities. For convicted addicts the Attorney General will have similar authority. We envision the proposed plan of treatment operating as follows:

As the time for the addict's discharge from the hospital approaches, the professional staff of the hospital, primarily involving the psychiatrist, psychologist, social worker and vocational counselor, together with the patent will assess his special needs and outline a plan of treatment to be followed upon his return to the community. When the plan for posthospital treatment has been arrived at, the hospital will communicate with the aftercare authority in the local community and give information on the patient's course of treatment in the hospital, his special needs and the plan of treatment outlined by the hospital personnel. The aftercare authority will respond by agreeing to accept responsibility for the addict indicating their ability to carry out the plan of treatment and will arrange for the necessary services. The addict will be released to the aftercare authority only when all arrangements have been completed. Upon the addict's arrival in the community the supervisory aftercare authority will assume responsibility for the addict and will make regular reports to the hospital on the patient's progress and any changes in the treatment plan which have been made. If it is determined that the individual has returned to the use of narcotics, the Surgeon General shall inform the court of the conditions under which the return occurred, and make a recommendation as to whether treatment should be continued. The court may affirm the commitment or terminate it and resume the pending criminal proceeding.

The kind of agencies we expect to utilize as supervisory aftercare authorities are as follows: halfway houses such as Southmore House in Houston, Tex., operated by the Vocational Guidance Service of Houston; the special clinic operated by the New York City Health Department whose primary interest is in providing step by step support for the addict emerging from hospital treatment so that he can find his place in society; the drug addiction program in New Jersey, newly established by the State department of mental health; the Drug Treatment and Rehabilitation Center in Boston, operated by the Massachusetts Department of Mental Health.

By designating specific agencies to be responsible for the addict upon discharge from the hospital and by paying for vocational, psychological, educational, and other services needed by the addict, we expect to reduce recidivism and to assist addicted persons toward productive living.

Through the maintenance of careful records during the patient's total treatment program, we expect to build a reservoir of knowledge about treatment methods which can be utilized, and to refine and delineate those programs of hospital and post-hospital care which are most successful in the rehabilitation of the narcotic addict and which can be used by other agencies interested in the addict. One of the most useful aspects of the treatment and rehabilitation programs

will be the increase in our store of knowledge about addiction, as we follow addicts through the aftercare program.

But significant gaps exist in our ability to gain the increased knowledge necessary to deal with addiction in the long run. Comprehensive and continuing statistical and biometric programs necessary for carrying out epidemiological and longitudinal studies of drug addiction and abuse are desirable. Provision for such a program is made in section 19(b) of H.R. 9051, and I would wholeheartedly support such an effort through appropriate amendments to the Public Health Service Act. Secondly, increased clinical research in the entire field of drug abuse is necessary.

In this regard, H.R. 9051 contains provisions which would expressly state the mission of the Public Health Service hospitals as including, in addition to care and treatment, "research, training, and demonstration in the techniques of treatment and social rehabilitation of addicts." We believe the mission of these hospitals already includes the functions of research, training, and demonstration.

H.R. 9051 also contains two major new program proposals. One is a program of Federal grants, which would authorize the appropriation of $15 million annually for 3 fiscal years to assist the States in the construction of facilities for the treatment of drug abusers. The second is a program of Federal grants, which would authorize the appropriation of $7.5 million annually for each of 3 fiscal years to assist the States and other public or nonprofit agencies in developing and providing services for the treatment and rehabilitation of drug abusers.

Unlike the proposals for civil commitment and sentencing convicted addict-offenders, these programs would apply to "drug abusers," which is given far greater scope by section 32 of H.R. 9051 than the present statutory definition of narcotic drug addicts.

The Department supports the principle of increased financial and technical assistance to State and local agencies for the establishment, maintenance, and expansion of comprehensive treatment and rehabilitation programs to deal with the problems of drug abuse in the broad sense thus defined, rather than in the narrower field of narcotic addiction alone. Grants to the States for construction of facilities are now provided for comprehensive community mental health centers under the Community Mental Health Centers Act and for hospital and medical facilities in accordance with State plans under the Hill-Burton Act. Since drug abuse is basically related to mental health problems we believe that assistance to the States in dealing with drug abuse should be accomplished within the framework of Federal aid to community mental health services rather than through a separate program. Further study is necessary, however before the magnitude of the drug abuse problem can be realistically assessed in terms of the facilities, resources, and personnel which would be required.

This does not negate the desirability of more intensive effort, with more Federal assistance to the States, in meeting the challenge of drug abuse. H.R. 2, the Drug Abuse Control Act of 1965, passed the House earlier this year by a unanimous vote of 420 to 0.

This new Federal legislation to regulate the traffic in nonnarcotic drugs, in addition to the present regulation of narcotic drugs, is an index to the growing, nationwide threat of drug abuse. Just as the Federal Government may well increase its effort in destroying the

illegal traffic in all dangerous drugs, it may well also increase its effort toward the further objectives of preventing drug abuse and rehabilitating its victims. The Community Mental Health Centers program offers the best means of dealing with the overall drug abuse problem.

To sum up the position of the Department in regard to the essential features of H.R. 9167 and H.R. 9051:

(1) We recognize that addicts are sick persons;

(2) We believe that addicts should come under medical supervision for treatment;

(3) We believe that with treatment, including adequate aftercare, increasing numbers of addicts will be returned to useful lives in the community;

(4) We recognize that more research and experience will be needed before this complex problem is solved;

(5) We believe that the intelligent, informed cooperation between the medical profession, the courts and the correctional agencies can contribute greatly to the solution of this problem;

(6) We believe that civil commitment, before trial, and sentencing to treatment after conviction, are desirable alternatives to criminal punishment for those addicts who seem likely to achieve rehabilitation through an adequate treatment program, provided these alternative methods are adequately implemented to maintain continuous, authoritative supervision of the addict throughout both institutional treatment and aftercare in the community;

(7) The Public Health Service role, in both hospital and community programs, should be complementary and supportive to State and local efforts. The Public Health Service hospital program itself should be one of integrated treatment, research, training, and technical assistance to the States, and should be coordinated with community programs in respect to the selection of patients and the provision of posthospital care.

Thank you, Mr. Chairman.

Mr. ASHMORE. Thank you, Dr. Terry, for your fine statement.

What is your opinion of the reference by Mr. Celler to the handling of this matter of procedure that is used in Great Britain? Do you think it has proven better than ours or would you follow their example?

Dr. TERRY. Dr. Yolles as a specialist in the field has considerable experience not only with our program in this country but is well acquainted with the program in Great Britain. I would like, if I may, to have him comment upon it.

Mr. ASHMORE. Doctor?

Dr. YOLLES. There has been a great deal of interest in the last 10 years or so in this so-called British system. In actuality there is no British system as such. The British themselves are reluctant to have us call it the British system. Actually the element of difference in Britain relates to medical practice. In Britain a physician may prescribe narcotics for an addict.

In actuality, this is used mainly for the withdrawal, in hospitals, of addicts and is only very rarely used by a physician to maintain addiction. Furthermore, in order to maintain addicts on drugs, as sometimes the popular press indicates is the British custom, the permission of the local medical group is necessary; and second, it has to

be demonstrated the individual can function better on drugs than he can without drugs.

In my experience with addicts—and in the number of years I have been associated with the addiction problem—I have yet to see an individual who has functioned better on drugs, of any sort whatsoever, than off. This is my own personal and professional opinion I am giving you now.

I would say this, however: There are a number of experimental programs going on now. One of them in particular in New York uses methadone, which is a synthetic analgesic, for the maintenance of drug addicts. The claims for this program are quite high. It is claimed that these persons are leading productive lives. The experiment is being carried on primarily by Dr. Vincent Dole, of the Rockefeller Institute, and presently working at Manhattan General Hospital under the auspices of the city of New York. He is an eminent investigator. However, the technique has not been proven worthwhile as yet. We do not have any controlled study as yet and it remains to be seen whether this is a valid way of treating addicts.

We do not wish to close off any avenues which might lead to the control of this disorder. We do not feel that we have all the answers as yet; not by a long shot. There are other drugs which have been suggested for use, such as cyclazocine. It has certain advantages and it does not lead to the drug-seeking behavior which is typical of the opiates and follows withdrawal from them.

These experiments are going on and we would like to see more experiments dealing with this problem area. We would not advocate any wide-scale or widespread use of maintenance treatment at this point in time, at least not until we have better evidence for such a procedure.

Mr. ASHMORE. My impression was that doctors in Great Britain are given more liberty in issuing of prescriptions for the use of narcotics. That occurs to me that that would not limit the use of it. However, some might think otherwise.

What is your opinion with reference to that, liberalization of prescriptions?

Dr. YOLLES. I frankly believe that the practice of medicine should be in medical hands. If the physician is charged with mishandling or misusing his prerogatives as a physician, this should be referred to a local medical group to see whether he acted ethically. However, I should point out to you that I am aware of an increase in addiction in Britain at the present time. The authorities in Britain are very concerned about it.

Mr. ASHMORE. Rather than decreasing it has increased?

Dr. YOLLES. Yes, sir.

Mr. ASHMORE. Thank you.

Mr. Gilbert?

Mr. GILBERT. Is that a percentage rise, Doctor? You are talking about the increase in Great Britain. Normally I think there had been an increase in the drug addiction in every country going up. I am just curious whether the percentage increase in England is going up less than say it is here or in other countries that do not have the English system.

Dr. YOLLES. That is a little hard to know. I do not know whether Commissioner Giordano has better figures than I have. I have heard of this increase. You realize that with a population of roughly 50 million in Britain. that for years there has been a total of about 450 addicts in all Britain. If this goes up to 700——

Mr. GILBERT. It is substantial?

Dr. YOLLES. Right. I am not aware of what the actual increase is.

Mr. GILBERT. With the little reading I have done on this subject, I thought it was working pretty well, the fact the physician could supply prescriptions and narcotics and so forth. I was hopeful it might be adopted here because of the success of the thing in England.

Dr. YOLLES. From all reports that we have had over the years, from the British Isles, it seemed to be working successfully. This is the first discordant note, if you will, that we have had. What the reasons for this reported increase are we do not know. Whether it is due to the introduction of persons from other countries into Great Britain or whether it is the introduction of organized crime into Britain, we do not know either. I do not profess to be an expert on that.

I am aware they have an increase in their problem.

Mr. GILBERT. You do have an increase in all countries in the world. This might be one of the factors involved at all age levels, particularly the youth. Violence begets violence and you find that there might be a gravitation in that respect for this type of thing, release for their inhibitions.

Dr. YOLLES. This may be.

Mr. ASHMORE. Mr. Grider?

Mr. GRIDER. First I would like to express my thanks to you for coming with us and spending so much of your time.

Dr. TERRY. Thank you.

Mr. GRIDER. What are the institutions which will be used to institutionalize these addicts when they are committed?

Dr. TERRY. We would expect to utilize primarily, and exclusively at the beginning, our hospitals at Lexington and Fort Worth.

Mr. GRIDER. Did you say they were already filled up?

Dr. TERRY. They are filled up, yes, sir, but we could, with regard to this, not take some of the other neuropsychiatric patients taken there, and we feel we can handle the load with the facilities we have largely.

It all depends upon particular circumstances. With the authority which would be given in the law, or in the proposed legislation, this could be carried out under contract. However, the responsibility still would be on the Surgeon General and the Public Health Service.

Mr. GRIDER. Was this program in line with what the Public Health Service decided when it closed some of these hospitals?

Dr. TERRY. I didn't think we could avoid that question with you, Mr. Grider. Yes, sir, this has been under consideration for several months. It is not anticipated that we would use to any great extent our general hospitals for the care of these patients.

Mr. GRIDER. Where would you put the neuropsychiatric patients which would have to be displaced?

Dr. TERRY. If they are veterans, as a very large number of them are, then the VA would have to take care of them in others of their hospitals.

Mr. GRIDER. Are these all veterans?

Dr. TERRY. About 200 at Fort Worth, for instance.

Mr. GRIDER. Have you been given assurance that the Veterans' Administration will take them?

Here is what troubles me: It seems to me if this program is to be effective, and I certainly hope it will be, you will need a larger number of beds than you have now. This is a rather ambitious program which may end in frustration because you do not have the available space.

Dr. TERRY. I do not feel that is true. As a matter of fact, when you consider that this legislation deals with Federal offenders, persons held by Federal authorities, there will not be a tremendous increase in the number of individuals involved.

Of course, in addition to moving other patients out of the hospital, we could accept fewer voluntary patients in our institutions.

Mr. GRIDER. The purpose of this legislation is to eliminate drug addiction, is it not?

Dr. TERRY. The purpose is to improve our present method of treatment of drug addiction; yes, sir.

Mr. GRIDER. Then it seems to me that if you throw out the voluntary patients at Lexington, for example, and accept the criminals, that you are discriminating against the law-abiding addict. Quite seriously, aren't we overlooking a very important factor?

Do you look on this as a pilot program, a test for the few criminal addicts?

Dr. TERRY. I think when you say "criminal" that you are using it in a very broad sense. Admittedly these people are charged with crimes, or convicted of crimes.

Mr. GRIDER. It is in some way related to their drug addiction.

Dr. TERRY. That is right.

Mr. GRIDER. The only answer that I have heard is that you will accept them by discarding some neuropsychiatric people or those who come voluntarily. It seems there should be a broader approach to this. Where will the facilities come from?

Mr. ASHMORE. Don't you also plan to use State facilities and other facilities?

Dr. TERRY. We will plan to use whatever facilities are appropriate in order to carry out the responsibilities; that is correct.

Mr. GRIDER. Do you know of any State institutions which are not now filled up that you could use?

Dr. TERRY. I don't know of any.

Dr. YOLLES. May I give you a quick rundown on what the facilities are in the United States generally? There are some 19 States that will accept addicts in their State hospitals.

In addition those 19 have specialized programs of one kind or another for the care of addicts, whether specialized clinics or special followup facilities. There are only three States which do not have any provision for the care of addicts nor do they accept them in the State hospitals.

Then there are another 31 which accept addicts in their State hospitals but have no specialized facilities other than the State hospital for treatment of addicts.

New York City has a large number of facilities of various kinds for treatment of addicts. Under the Metcalf Act there are roughly 455

beds in the State for the treatment of addicts all of which are not being used.

Mr. GRIDER. How many?

Dr. YOLLES. 455. I can give you the rundown by hospital as they have been reported to us by the State department of mental hygiene.

Mr. GRIDER. That will not get the job done, will it?

Dr. YOLLES. In regard to the Lexington Hospital, for example, you must realize that if a good number of these individuals are civilly committed after the first few years this will reduce the number of prisoner-patients in the Lexington Hospital.

Mr. GRIDER. We have heard today 43 percent of the addicts in Federal prisons are not there because of violations of the Federal narcotics law. Are they now not eligible for Lexington? If they are selected I gather they will be under this new legislation.

Dr. YOLLES. Those individuals are presently eligible. Any person who is incarcerated in the Bureau of Prisons who is an addict may, at the discretion of the Attorney General, be sent to Lexington.

Mr. GRIDER. In any event it is the objective of this legislation to bring a larger number of them under treatment. You said certain States are willing to accept them. How many of those States have beds and how many? Where will you put these patients? I still haven't an answer to that question.

Dr. YOLLES. With the reduction of the number of criminal patients who would be coming in solely as Federal prisoners there will be a number of beds released. Temporarily we may have to reduce the number of volunteers. It is a semantic difference as to whether you say someone is charged with a crime and comes in as a prisoner or a civil committee or a volunteer. Most of the volunteers have criminal records in addition to their addiction.

What needs to be pointed out is this: We have for years tried to develop within the States—we have urged and worked with each of the States to develop programs for the care of addicts.

The record will show that this has not eventuated, with the exception of the two States that have the largest program, namely, New York and California.

The Federal Government in our opinion does not have the sole responsibility for the control of drug addiction or drug abuse in the United States. We are willing to be partners, if you will, with the appropriate departments in the several States for the control of the problem, but I don't think our own hospitals should be responsible for trying to cut down on the total problem of drug addiction.

I make this reference only in relation to possible reduction in the number of volunteers who might come in from the States.

Mr. GRIDER. Do you think it would be well to incorporate a plan to build some additional facilities? Honestly, don't you think you will need more facilities than you presently have or can get if this act is to be effective?

Dr. YOLLES. In certain States, and if you are dealing with the problem of drug use generally rather than the much narrower problem of narcotic addiction which is restricted mainly to five States, then there is a question of need for facilities.

However, I would like to put it in the context of a mental health problem. I think all the professionals in the field think this is a

mental health problem. We would like to see the development of facilities in relation to the newly developing comprehensive community mental health centers.

There is ample legislative history associated with Public Law 88–164 to allow for the treatment of addicts in such community mental health centers.

States presently are coming in with plans for construction of such centers.

In those States which have a large drug abuse problem we would feel, as the Surgeon General has said, it might be appropriate for them to come in for special application to add to the community mental health centers such specialized facilities for the treatment of drug abuse as might be needed. However, we do not feel it would be appropriate to develop specialized facilities for narcotic use or drug addiction which are separate and distinct from a community mental health center because we feel that the patient, regardless of whether he is a drug abuser or a schizophrenic, should have available to him the full complement of services which will be available in the mental health centers. There they can move easily and quickly from one type of service to another with a minimum of delay and redtape.

This is the approach we have developed in the new national mental health program.

Mr. SHATTUCK. I think in this questioning we are talking about a problem concerning individuals and numbers of individuals. In your Department, or in the course of your study, have you evolved an estimate of just how many people per year would be eligible for this civil commitment procedure?

Dr. FERRAZZANO. We have done a profile of the patients and have contacted the Justice Department and Treasury Department in trying to get some type of figure. We have come up with a figure of approximately 1,300 per year that would come to the attention of the courts. We estimate that of these 1,300, about 100 would not qualify. About 1,200 would be examined for the 20 to 30 days before the Surgeon General would determine whether or not treatment should be entertained. We felt that perhaps a fourth of these would be returned to the court as not being eligible. Therefore we are talking about 900 people who would be treated per year.

Mr. SHATTUCK. Between 900 and 1,000 people who would ultimately be treated in accordance with this new procedure.

Dr. FERRAZZANO. That is right.

There is one point I would like to mention and that is that the mandatory sentence now in effect keeps the prisoner in our institution on the average of over 2 years, although we feel he does not require any additional medical help.

Under H.R. 9157, the prisoner could be released whenever we felt that he was ready to go back to the community. We would have a much quicker turnover of beds so we could handle many more patients in Lexington than we now do. The prisoners are holding down beds because of the mandatory sentence.

Mr. SHATTUCK. This may not relate to the question, but I think it is assumed in connection with this group of bills that you will deal with an individual who is willing to be helped and cooperate.

Dr. FERRAZZANO. That is right.

Mr. SHATTUCK. Therefore, the chance for ultimate success, we would hope, would be much better than some of the statistics we have heard would seem to indicate.

Dr. FERRAZZANO. That is correct. Furthermore, those who go out under posthospital care and are still under the control of the hospital, so to speak, will be expected to do better because now those prisoners who do go out on parole in fact do much better than the ones who are discharged directly to the community. If there is some type of supervision over them in the community we find right now that they do much better.

Mr. ASHMORE. Is it true that most addicts really want to get off of it permanently?

Dr. TERRY. I don't know how to answer that.

Mr. ASHMORE. I mean when they are normal.

Dr. YOLLES. I think when talking to an addict who has been off of narcotics for a number of months, perhaps a year, he will admit that he is more comfortable not going through the hurly-burly of trying to find bread, as they call it, in other words, to get the money to support his habit.

On the other hand they will also tell you, "You don't know what you are missing, Doc. It is the most wonderful substance in the world to take care of all your cares and aches and pains. When you are under it you have no cares whatsoever."

However, I think after dealing with a person for some time trying to treat some of his psychological quirks, and making the first inroads, he will then admit that he feels more comfortable without the drug, without the necessity for seeking it, and without the necessity for being at cross purposes with the rest of society.

Mr. HOFFMANN. Can you give us the figures on what percentage of the patients at Lexington are presently Federal prisoners?

Dr. TERRY. For 1964, where there were 2,515 admissions during the year, 405 of those were prisoners; 1,687 were voluntary addicts, or voluntary admissions of addicts, and 27 were Federal probationer addicts.

If that is stated differently, in terms of the numbers of beds occupied at a time, it gives a different picture.

For instance, there was an average daily patient load of 1,035, and of those 940 were addicts, of whom 619 were prisoners. In other words, the prisoners bed occupancy was about 60 percent.

Mr. HOFFMANN. What is the difference in the facilities required in terms of security? Does it require more manpower? There was a comment earlier today that many of these State institutions, either in New York or in California, are not set up to handle the security aspects of treating these prisoners.

Dr. TERRY. I would like Dr. Yolles to comment on this, please.

Dr. YOLLES. I think much can be said about the security aspect in terms of bringing narcotics into the unit. If you are talking about the security aspects in regard to eloping, that is another matter.

We like to think of dealing with any type of mental patient in the same way we deal with patients in State mental hospitals and our own service hospitals. We have found that the need for stringent security is far less than we imagine.

I think our experience at Lexington has shown you do not need very stringent security and I do not think you need that much more personnel than you ordinarily would use at any mental hospital, on a locked ward, for example.

Mr. HOFFMANN. So when we talk about taking on more people, whether they are civil committees or where they have a criminal charge hanging over them, no significant alteration of your facilities is required to accommodate them?

Dr. TERRY. None.

Mr. HOFFMANN. I have a different subject, approaching the problem of civil commitment from strictly the law enforcement point of view. The Attorney General testified that under the administration bill you would have a man eligible for civil commitment and his trial held over who would be charged with a crime which, (*a*) was not a narcotic offense; and, (*b*) was not necessarily a product of his being and addict. For example, a man who steals a car in New York and drives it to Washington. When he is picked up he is an addict. It turns out stealing the car had nothing to do ostensibly with being an addict. Yet he is given the opportunity to trade his cure for the punishment which normally would be imposed if he were not an addict.

I would like you to comment on the thing that would justify such a swap, if you will. He is totally beyond the power of free choice, and should he be given this option?

Dr. TERRY. This is largely a legal question and perhaps I should not even attempt to answer it at all.

Mr. HOFFMANN. I am asking you whether you think this is valid, treating him on the basis that he is not guilty by reason of drug addiction.

Dr. TERRY. This is the sort of situation where I would expect the discretion of the judge to prevail in terms of which patients he in effect offered civil commitment to and which he did not offer it to. There are certain limitations, statutory limitations which prevent the providing of civil commitment to some, but on the other hand it does not state that the judge has to accept all of these others.

I imagine in circumstances like this the judge, in consultation with the law enforcement agencies and with the Public Health Service in relation to the medical aspects, would make the decision as to whether or not this individual should be, in effect, offered civil commitment.

Mr. HOFFMANN. So in your judgment when this act becomes law in part of the legislative history at which the judge can look in making his initial determination there should be some element in there of causality between the addiction and the crime he committed.

Dr. TERRY. I don't know that is necessarily true, that one would have to say that what he did was caused completely by the drug in order for civil commitment proceedings to be acceptable.

On the other hand, one could say that when you look at this man as an individual the thing that caused him to be a drug addict might cause him to commit some other crime, though drug addiction per se was not responsible.

If you are looking at this person as an individual, and you hope to correct his basic personality disorders and make him a person who can cope with the problem of drug addiction, it is well worth the invest-

ment. To my mind it would not necessarily have to be tied to the use of drugs.

Mr. SHATTUCK. In this situation the judge is called upon to make another determination which has to take into consideration all the facts, not only the drug addiction but also the man's record, the recommendations of the U.S. attorney, I imagine, and the Public Health Service, so I do not think the thrust of this legislation necessarily requires the determination of a direct connection between drug addiction and the violation of Federal law, whatever it might be.

Dr. TERRY. I would agree with this. I don't know whether Dr. Yolles would like to add anything to that or not.

Dr. YOLLES. No, sir.

Mr. HOFFMANN. The difference in the two situations is simply this: When a judge puts a man on parole or probation or in prison, the man has been found guilty. He either pleaded guilty or has been found guilty. He is held to account.

In giving him an alternative before he is found guilty, is it not true we are taking away from you some therapeutic advantage in having him held to account? He is thereafter not an exception to society's rule, but a sick man, and he goes on from there.

Dr. TERRY. If I understand you correctly I think it would be the opposite. In other words, it would offer to this man a period of time under which he would be under supervision, surveillance, and receiving treatment and assistance to adjust himself. In that way he would realize that over this period of time the potentiality of this charge against him still holds sway, but that if he corrected himself and were able to straighten out he would not have a conviction on the records of the courts.

I think this would be a significant motivating factor. Rather than going ahead and being convicted and then going through it in that direction I think that the civil commitment would add considerably to the inducement to this individual.

Mr. HOFFMANN. You don't think the youth correction remedy of expunging or vacating the sentence, expunging the record upon successful completion of this period, has that same effect?

Dr. TERRY. I really don't know. I am not well enough acquainted with it to comment.

Mr. ASHMORE. Further questions?

If not this will conclude the hearing today.

Thank you very much for coming, gentlemen.

The executive communication from the Department of Justice and the Treasury Department recommending the provisions of the bill, H.R. 9167, introduced by Chairman Celler, will be made part of the record at this point of the proceedings.

OFFICE OF THE ATTORNEY GENERAL,
Washington, D.C., June 15, 1965.

THE SPEAKER,
House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: Enclosed for your consideration and appropriate reference is a legislative proposal to amend title 18 of the United States Code to enable the courts to deal more effectively with the problem of narcotic addiction, and for other purposes.

At the White House Conference on Narcotic and Drug Abuse, September 1962, many representatives concluded that a procedure should be established under

which addicts convicted of a violation of law could be dealt with in better ways than are now available. Further, it was agreed that the penalty structure for sentencing narcotic and marihuana offenders should be modified. These views were reiterated in the final report of the President's Advisory Commission on Narcotic and Drug Abuse, November 1963. In addition, these recommendations were supported by the President in his special message to the Congress on "Crime, Its Prevalence, and Measures of Prevention," dated March 8, 1965. The enclosed legislative proposal would implement the recommendations of the Conference, the Commission, and the President.

Basically, title I of the legislation would establish a procedure through which a narcotic addict charged with a criminal offense could be civilly committed to the custody of the Surgeon General for treatment in lieu of facing criminal prosecution on the charge against him. This would be accomplished by the court when it has reason to believe him to be an addict and also has reason to believe he is likely to be rehabilitated by proper treatment. In such an instance, the court could afford the defendant the option to elect to submit to a physical examination by the Surgeon General to determine whether he is in fact an addict. If, upon receiving the report of the Surgeon General and his recommendation as to whether the defendant should be civilly committed, the court directs such commitment, the criminal charge is held in abeyance pending the successful completion of institutional and aftercare treatment. At that time the charge would be dismissed, but if before that time the defendant is found unresponsive or uncooperative in treatment, the civil commitment may be terminated and the criminal proceedings resumed.

Since a defendant must elect within 5 days after his first appearance in court whether to submit himself to an examination which might result in a civil commitment, this procedure not only provides an opportunity to get at what may be one of the underlying causes of criminal activity, but it has the significant advantage of swiftly effecting the removal from the streets of addicts who may be restored to useful citizenship.

Title II of the proposed legislation would amend title 18 of the United States Code to add a chapter providing for the indeterminate sentencing of narcotic addicts to treatment following conviction for criminal activity. As with title I, this title would provide a program of comprehensive treatment for addicts placed in the custody of the Attorney General after conviction.

Both the civil commitment procedure and the procedure for sentencing to treatment following conviction require as a condition to their use that the court find a person charged with a criminal offense is an addict and is likely to be rehabilitated by treatment. Furthermore, in both instances, safeguards are provided to assure that uncooperative or unresponsive individuals will not be released, or if already released, they will be returned to institutional custody. Further, if such individuals had been committed under title I, they would face prosecution on the pending charge. Treatment procedures have been limited to exclude from their applicability certain persons who sell narcotic drugs, persons with repeated felony convictions, and other persons who are not considered suitable subjects for treatment and rehabilitation. Both facets of the legislation provide for institutional treatment and supervisory aftercare following release from confinement. In civil commitment the Surgeon General, and in commitment following conviction the Attorney General, would be authorized to contract with appropriate public or private agencies or persons for the supervisory aftercare. It is thus expected that local community personnel and facilities will play a significane role in this aspect of the treatment program.

Title III of the legislation would modify certain exclusionary features of the Young Adult Offenders Act of 1958 (Public Law 85–752, 72 Stat. 845) by making any narcotic drug or marihuana offender over the age of 22 and under the age of 26 eligible to receive an indeterminate sentence and conditional release under the Federal Youth Corrections Act. However, it would retain the provision that suspended sentence and probation shall not be available under the Federal Youth Corrections Act to offenders convicted of certain narcotics or marihuana offenses which require mandatory penalties.

The title would also amend section 103 of the Narcotic Control Act of 1956 (Public Law 84–728, 70 Stat. 567) by making the provisions of parole under section 4202 of title 18, United States Code, and the act of July 15, 1932 (47 Stat. 696; D.C. Code 24–201 and following), as amended, available to all marihuana offenders.

In addition, it would permit the Board of Parole to review the sentences of prisoners who now stand convicted of marihuana offenses and prisoners con-

victed of a violation of a law relating to narcotic drugs who had not attained the age of 26 at the time of conviction. The Board would be authorized to release such persons on parole or place them under the provisions of the Federal Youth Corrections Act as may be deemed suitable.

This title would permit greater latitude in handling certain violators when deemed necessary to individualize rehabilitative treatment, and at the same time leave intact the overall deterrent characteristics of the mandatory penalties contained in the Narcotic Control Act of 1956.

In summary, the enclosed proposal represents a creative approach to accomplish what was implicit in the President's statement that it is essential to "seek to the fullest extent consistent with the public safety to give offenders a maximum opportunity for return to a normal life." Through the joint efforts of the courts and medical, correctional, and legal authorities, it is hoped that this legislation will be a key toward the rehabilitation of a substantial number of persons charged with crime and their resumption of productive places in society.

The Bureau of the Budget has advised that enactment of this legislation is in accord with the program of the President.

Sincerely,

NICHOLAS DEB. KATZENBACH,
Attorney General.
HENRY H. FOWLER,
Secretary of the Treasury.

A BILL To amend title 18 of the United States Code to enable the courts to deal more effectively with the problem of narcotic addiction, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That titles I and II of this Act may be cited as the "Narcotic Addict Rehabilitation Act of 1965."

DECLARATION OF POLICY

SEC. 2. It is the policy of the Congress that certain individuals charged with, or convicted of, violating Federal laws should be afforded an opportunity for treatment if it is determined that they are narcotic addicts and such treatment is likely to result in their rehabilitation and return to society as useful members. It is the further policy of the Congress that alternative procedures should be afforded for use in sentencing certain individuals convicted of violating Federal laws relating to narcotic drugs or marihuana.

TITLE I—CIVIL COMMITMENT IN LIEU OF PROSECUTION

DEFINITIONS

SEC. 101. As used in this title—

(a) "Addict" means any individual who habitually uses any narcotic drug as defined by section 4731 of the Internal Revenue Code of 1954, as amended, so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

(b) "Surgeon General" means the Surgeon General of the Public Health Service.

(c) "Crime of violence" includes voluntary manslaughter, murder, rape, mayhem, kidnaping, robbery, burglary, housebreaking, extortion accompanied by threats of violence, assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for more than one year, arson punishable as a felony, or an attempt to commit any of the foregoing offenses.

(d) "Treatment" includes treatment in an institution and under supervised aftercare in the community and includes, but is not limited to, medical, educational, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by correcting his antisocial tendencies and ending his dependence on addicting drugs and his susceptibility to addiction.

(e) "Felony" includes any offense in violation of a law of the United States, any State, any possession or territory of the United States, the District of Columbia, the Canal Zone, or the Commonwealth of Puerto Rico, which at the time of the offense was punishable by death or imprisonment for a term exceeding one year.

(f) "Conviction" and "convicted" mean the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere, but do not include a final judgment which has been expunged by pardon, reversed, set aside or otherwise rendered nugatory.

(g) "Eligible individual" means any individual who is charged with an offense against the United States, but does not include—

(1) An individual charged with a crime of violence.

(2) An individual charged with selling a narcotic drug, unless the court determines that such sale was for the primary purpose of enabling the individual to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug.

(3) An individual against whom there is pending a prior charge of a felony which has not been finally determined or who is on probation or whose sentence following conviction of such a charge, including any time on parole or mandatory release, has not been fully served: *Provided*, That an individual on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment.

(4) An individual who has been convicted of a felony on two or more occasions.

(5) An individual who has been civilly committed under this Act or any State proceeding because of narcotic addiction on two or more occasions.

PROCEEDINGS BEFORE COURT

SEC. 102. (a) If a United States district court believes that an eligible individual is an addict, the court may advise him at his first appearance that the prosecution of the criminal charge will be held in abeyance if he elects to submit to an immediate examination to determine whether he is an addict and is likely to be rehabilitated through treatment. In offering an individual an election, the court shall advise him that if he elects to be examined, he will be confined during the examination for a period not to exceed sixty days; that if he is determined to be an addict who is likely to be rehabilitated, he will be civilly committed to the Surgeon General for treatment; that he may not voluntarily withdraw from the examination or any treatment which may follow; that the treatment may last for thirty-six months; that during treatment, he will be confined in an institution and, at the discretion of he Surgeon General, he may be conditionally released for supervised aftercare treatment in the community; and that if he successfully completes treatment the charge will be dismissed, but if he does not, prosecution on the charge will be resumed. An individual shall be permitted a maximum of five days after his appearance in which to elect, and he shall be so advised. Except on a showing that a timely election could not have been made, an individual shall be barred from an election after the prescribed period. An individual who elects civil commitment shall be placed in the custody of the Attorney General or the Surgeon General, as the court directs, for an examination by the Surgeon General during a period not to exceed thirty days. This period may, upon notice to the court and the appropriate United States attorney, be extended by the Surgeon General for an additional thirty days.

(b) The Surgeon General shall report to the court the results of the examination and recommend whether the individual should be civilly committed. A copy of the report shall be made available to the individual and the United States Attorney. If the court, acting on the report and other information coming to its attention, determines that the individual is not an addict or is an addict not likely to be rehabilitated through treatment, the individual shall be held to answer the abeyant charge. If the court determines that the individual is an addict and is likely to be rehabilitated through treatment, the court shall commit him to the custody of the Surgeon General for treatment. No individual shall be committed under this title if the Surgeon General certifies that adequate facilities or personnel for treatment are unavailable.

(c) Whenever an individual is committed to the custody of the Surgeon General for treatment under this title, the criminal charge against him shall be continued without final disposition and shall be dismissed if the Surgeon General certifies to the court that the individual has successfully completed the treatment program. On receipt of such certification, the court shall discharge the individual from custody. If prior to such certification the Surgeon General determines that

the individual cannot further treated as a medical problem, he shall advise the court. The court shall thereupon terminate the commitment, and the pending criminal proceeding shall be resumed.

(d) An individual committed for examination or treatment shall not be released on bail or on his own recognizance.

COMMITMENT

SEC. 103. (a) An individual who is committed to the custody of the Surgeon General for treatment under this title shall not be conditionally released from institutional custody until the Surgeon General determines that he has made sufficient progress to warrant release to a supervisory aftercare authority. If the Surgeon General is unable to make such a determination at the expiration of twenty-four months after the commencement of institutional custody, he shall advise the court and the appropriate United States Attorney whether treatment should be continued. The court may affirm the commitment or terminate it and reusme the pending criminal proceeding.

(b) An individual who is conditionally released from institutional custody shall, while on release, remain in the legal custody of the Surgeon General and shall report for such supervised aftercare treatment as the Surgeon General directs. He shall be subject to home visits and to such physical examination and reasonable regulation of his conduct as the supervisory aftercare authority establishes, subject to the approval of the Surgeon General. The Surgeon General may, at any time, order a conditionally released individual to return for institutional treatment. The Surgeon General's order shall be a sufficient warrant for the supervisory aftercare authority, a United States marshal, a probation officer, or an agent of the Attorney General, to apprehend and return the individual to institutional custody as directed. If it is determined that an individual has returned to the use of narcotics, the Surgeon General shall inform the court of the conditions under which the return occurred and make a recommendation as to whether treatment should be continued. The court may affirm the commitment or terminate it and resume the pending criminal proceeding.

(c) The total period of treatment for any individual committed to the custody of the Surgeon General shall not exceed thirty-six months. If, at the expiration of such maximum period, the Surgeon General is unable to certify that the individual has successfully completed his treatment program the pending criminal proceeding shall be resumed.

(d) Whenever a pending criminal proceeding against an individual is resumed under this title, he shall receive full credit toward the service of any sentence which may be imposed for any time spent in the institutional custody of the Surgeon General or the Attorney General or any other time spent in institutional custody in connection with the matter for which sentence is imposed.

CIVIL COMMITMENT NOT TO BE A CONVICTION

SEC. 104. The determination of narcotic addiction and the subsequent civil commitment under this title shall not be deemed a criminal conviction. The results of any tests or procedures conducted by the Surgeon General or the supervisory aftercare authority to determine narcotic addiction may only be used in a further proceeding under this title. They shall not be used against the examined individual in any criminal proceeding except that the fact that he is a narcotic addict may be elicited on his cross-examination as bearing on his credibilty as a witness.

USE OF FEDERAL, STATE, AND PRIVATE FACILITIES

SEC. 105. (a) The Surgeon General may from time to time make such provision as he deems appropriate authorizing the performance of any of his functions under this title by any other officer or employee of the Public Health Service, or with the consent of the head of the department or agency concerned, by any Federal or other public or private agency or officer or employee thereof.

(b) The Surgeon General is authorized to enter into arrangements with any public or private agency or any person under which appropriate facilities or services of such agency or person will be made available, on a reimbursable basis or otherwise, for the examination or treatment of individuals who elect civil commitment under this title.

TITLE II—SENTENCING TO COMMITMENT FOR TREATMENT

SEC. 201. Title 18 of the United States Code is amended by adding after chapter 313 thereof the following new chapter:

"CHAPTER 314—NARCOTIC ADDICTS

Sec.
4251. Definitions.
4252. Examination.
4253. Commitment.
4254. Conditional release.
4255. Supervision in the community.

§ 4251. Definitions

As used in this chapter—

(a) "Addict" means any individual who habitually uses any narcotic drug as defined by section 4731 of the Internal Revenue Code of 1954, as amended, so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

(b) "Crime of violence" includes voluntary manslaughter, murder, rape, mayhem, kidnaping, robbery, burglary, housebreaking, extortion accompanied by threats of violence, assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for more than one year, arson punishable as a felony, or an attempt to commit any of the foregoing offenses.

(c) "Treatment" includes treatment in an institution and under supervised aftercare in the community and includes, but is not limited to, medical, educational, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by correcting his antisocial tendencies and ending his dependence on addicting drugs and his susceptibility to addiction.

(d) "Felony" includes any offense in violation of a law of the United States, any State, any possession or territory of the United States, the District of Columbia, the Canal Zone, or the Commonwealth of Puerto Rico, which at the time of the offense was punishable by death or imprisonment for a term exceeding one year.

(e) "Conviction" and "convicted" mean the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere, and do not include a final judgment which has been expunged by pardon, reversed, set aside or otherwise rendered nugatory.

(f) "Eligible offender" means any individual who is convicted of an offense against the United States, but does not include—

(1) An offender who is convicted of a crime of violence.

(2) An offender who is convicted of selling a narcotic drug, unless the court determines that such sale was for the primary purpose of enabling the offender to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug.

(3) An offender against whom there is pending a prior charge of a felony which has not been finally determined or who is on probation or whose sentence following conviction on such a charge, including any time on parole or mandatory release, has not been fully served: *Provided*, That an offender on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment.

(4) An offender who has been convicted of a felony on two or more prior occasions.

(5) An offender who has been committed under title I of the Narcotic Addict Rehabilitation Act of 1965, under this chapter, or under any State proceeding because of narcotic addiction on two or more occasions.

§ 4252. Examination

If the court believes that an eligible offender is an addict, it may place him in the custody of the Attorney General for an examination to determine whether he is an addict and is likely to be rehabilitated through treatment. The Attorney General shall report to the court within thirty days; or any additional period granted by the court, the results of such examination and make any recommendations he deems desirable. No offender shall be committed under this chapter if

the Attorney General certifies that adequate facilities or personnel for treatment are unavailable. An offender shall receive full credit toward the service of his sentence for any time spent in custody for an examination.

§ 4253. Commitment

(a) If the court determines that an eligible offender is an addict and is likely to be rehabilitated through treatment, it shall commit him to the custody of the Attorney General for treatment under this chapter. Such commitment shall be for an indeterminate period of time not to exceed ten years, but in no event shall it exceed the maximum sentence that could otherwise have been imposed.

(b) If the court determines that an eligible offender is not an addict, or is an addict not likely to be rehabilitated through treatment, it shall impose such other sentence as may be authorized or required by law.

§ 4254. Conditional release

An offender committed under section 4253(a) may not be conditionally released until he has been treated for six months in an institution maintained or approved by the Attorney General for treatment. The Attorney General may then or at any time thereafter report to the Board of Parole whether the offender should be conditionally released under supervision. After receipt of the Attorney General's report, and certification from the Surgeon General of the Public Health Service that the offender has made sufficient progress to warrant his conditional release under supervision, the Board may in its discretion order such a release. In determining suitability for release, the Board may make any investigation it deems necessary. If the Board does not conditionally release the offender, or if a conditional release is revoked, the Board may thereafter grant a release on receipt of a further report from the Attorney General.

§ 4255. Supervision in the community

An offender who has been conditionally released shall be under the jurisdiction of the Board as if on parole under the established rules of the Board and shall remain, while conditionally released, in the legal custody of the Attorney General. The Attorney General may contract with any appropriate public or private agency or any person for supervisory aftercare of a conditionally released offender. Upon receiving information that such an offender has violated his conditional release, the Board, or a member thereof, may issue and cause to be executed a warrant for his apprehension and return to custody. Upon return to custody, the offender shall be given an opportunity to appear before the Board, a member thereof, or an examiner designated by the Board, after which the Board may revoke the order of conditional release.

TITLE III—SENTENCING AFTER CONVICTION FOR VIOLATION OF LAW RELATING TO NARCOTIC DRUGS OR MARIHUANA

SEC. 301. Section 7 of the joint resolution of August 25, 1958 (72 Stat. 845), is amended to read as follows:

"SEC. 7. This Act does not apply to any offense for which a mandatory penalty is provided; except that section 4209 of title 18, as amended, shall apply to any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended."

SEC. 302. Section 4209 of title 18, United States Code, is amended by (1) inserting immediately before the first sentence thereof "(a)" and (2) adding at the end thereof the following new subsections:

"(b) A defendant described in subsection (a) of this section who is convicted of a violation of any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended, shall, if the court is considering sentencing him to the custody of the Attorney General pursuant to the provisions of the Federal Youth Corrections Act, be committed to the custody of the Attorney General for observation and study in accordance with the provisions of section 5010(e) of this title. Before sentencing such a defendant to the custody of the Attorney General for treatment and supervision pursuant to the Federal Youth Corrections Act, the court must affirmatively find, in writing, that there is reasonable ground to believe that the defendant will benefit from the treatment provided thereunder.

"(c) Section 5010(a) of this title shall not be applicable to a defendant described in subsection (a) of this section who is convicted of a violation of any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended."

SEC. 303. Section 7237(d) of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(d) No suspension of sentence; no probation; etc.—Upon conviction—

(1) of any offense the penalty for which is provided in subsection (b) of this section, subsection (c), (h), or (i) of section 2 of the Narcotic Drugs Import and Export Act, as amended, or such Act of July 11, 1941, as amended, or

(2) of any offense the penalty for which is provided in subsection (a) of this section, if it is the offender's second or subsequent offense,

the imposition or execution of sentence shall not be suspended, probation shall not be granted, and in the case of a violation of a law relating to narcotic drugs, section 4202 of title 18, United States Code, and the Act of July 15, 1932 (47 Stat. 696; D.C. Code 24–201 and following), as amended, shall not apply."

SEC. 304. The Board of Parole is hereby directed to review the sentence of any prisoner who, before the enactment of this Act, was made ineligible for parole by section 7237(d) of the Internal Revenue Code of 1954, as amended, and (1) who was convicted of a violation of a law relating to marihuana or (2) who was convicted of a violation of a law relating to narcotic drugs and had not attained his 26th birthday prior to such conviction. After conducting such review the Board of Parole may authorize the release of such prisoner on parole pursuant to section 4202 of title 18, United States Code. If the Board of Parole finds that there are reasonable grounds to believe that such prisoner may benefit from the treatment provided under the Federal Youth Corrections Act (18 U.S.C. Chapter 402), it may place such prisoner in the custody of the Youth Corrections Division of the Board of Parole for treatment and supervision pursuant to the provisions of the Federal Youth Corrections Act. Action taken by the Board of Parole under this section shall not cause any prisoner to serve a longer term than would be served under his original sentence.

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. Section 341 of the Public Health Service Act, as amended (58 Stat. 698; 68 Stat. 80; 70 Stat. 622; 42 U.S.C. 257) is amended to read as follows:

"SEC. 341(a). The Surgeon General is authorized to provide for the confinement, care, protection, treatment and discipline of persons addicted to the use of habit-forming narcotic drugs who are civilly committed to treatment or convicted of offenses against the United States and sentenced to treatment under the Narcotic Addict Rehabilitation Act of 1965, addicts who are committed to the custody of the Attorney General pursuant to the provisions of the Federal Youth Corrections Act, addicts who voluntarily submit themselves for treatment, and addicts convicted of offenses against the United States and who are not sentenced to treatment under the Narcotic Addict Rehabilitation Act of 1965, including persons convicted by general courts-martial and consular courts. Such care and treatment shall be provided at hospitals of the Service especially equipped for the accommodation of such patients or elsewhere where authorized under other provisions of law, and shall be designed to rehabilitate such persons, to restore them to health, and, where necessary, to train them to be self-supporting and self-reliant, but nothing in this section or in this part shall be construed to limit the authority of the Surgeon General under other provisions of law to provide for the conditional release of patients and aftercare under supervision.

(b) Upon the admittance to, and departure from, a hospital of the Service of a person who voluntarily submitted himself for treatment pursuant to the provisions of this section, and who at the time of his admittance to such hospital was a resident of the District of Columbia, the Surgeon General shall furnish to the Commissioners of the District of Columbia or their designated agent, the name, address, and such other pertinent information as may be useful in the rehabilitation to society of such person."

SEC. 402. The Surgeon General and the Attorney General are authorized to give representatives of States and local subdivisions thereof the benefit of their experience in the care, treatment, and rehabilitation of narcotic addicts so that each State may be encouraged to provide adequate facilities and personnel for the care and treatment of narcotic addicts in its jurisdiction.

SEC. 403. The table of contents to "Part III.—Prison and Prisoners" of title 18, United States Code, is amended by inserting after "313. Mental defectives * * * 4241" a new chapter reference as follows: "314. Narcotic addicts * * * 4251".

SEC. 404. If any provision of this Act or the application thereof to any person or circumstance is held invalid, the remainder of the Act and the application of such provision to other persons not similarly situated or to other circumstances shall not be affected thereby.

SEC. 405. Title I of this Act shall take effect three months after the date of its enactment and shall apply to any case pending in a district court of the United States in which an appearance has not been made prior to such effective date. Titles II and III of this Act shall take effect on the date of its enactment and shall apply to any case pending in any court of the United States in which sentence has not yet been imposed as of the date of enactment.

SEC. 406. There are authorized to be appropriated such sums as are necessary to carry out the provisions of this Act.

We shall resume the hearings tomorrow morning at 10 o'clock.

PROVIDING FOR CIVIL COMMITMENT AND TREATMENT OF NARCOTIC ADDICTS

THURSDAY, JULY 15, 1965

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE NO. 2 OF THE
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10:05 a.m., in room 4121, Rayburn House Office Building, Hon. Robert T. Ashmore (chairman of the subcommittee) presiding.

Mr. ASHMORE. The committee will come to order. We will resume our hearings on H.R. 9051 and H.R. 9167.

Yesterday we heard from a number of witnesses from the departments on these bills and other bills on the same subject. This morning we have prominent witnesses from the Senate and also House Members. The first witness listed for testimony this morning is Senator Robert Kennedy of New York. Senator, we are glad to have you with us.

STATEMENT OF HON. ROBERT F. KENNEDY, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator KENNEDY. Thank you.

Mr. ASHMORE. Senator, you can give us your statement in full, or, as we have copies of it, if you like, you can summarize. Use whatever method you like.

Senator KENNEDY. I will proceed and perhaps there will be parts I would like to leave out in the interest of brevity.

Mr. Chairman, I am glad to be able to appear this morning to testify regarding proposed narcotic legislation. I am most heartened, Mr. Chairman, by your undertaking so promptly to hold hearings on the various bills that have been introduced this year. With this kind of expeditious consideration, we can be realistic in expecting prompt action by Congress in reforming the Federal criminal law as it deals with addiction and in providing a program of Federal aid to States and local communities to help them in their efforts to treat and rehabilitate addicts.

Of all the social problems with which we in Congress might seek to deal, perhaps none is more deeply associated with sheer human misery than narcotics. The matter is not just one of numbers, although its statistical dimensions are certainly significant. The President's Advisory Committee stated in 1963 that estimates of the number of addicts in the United States range from 45,000 to 100,000. Others say there are more, and when one takes into account the number of people

using barbiturates and amphetamines and other dangerous drugs, the total is unquestionably much higher.

Beyond mere numbers, however, the degradation and misery of the addict's situation and its effect on his family and loved ones are matters which defy statistical classification, and the crime which the typical addict must commit to support his addiction is of staggering proportions. The addict's cycle—his day-in, day-out alternation between the search for a "fix" and the satisfaction of having found one—leaves no room for anything but a shambles of family life. Whether he lives with a parent or a wife or whatever, the result can only be emotional chaos and continuing economic crisis.

And the problem is most difficult to deal with. Now, more than at any other time in our history, the addict is a product of a society which has moved faster and further than it has allowed him to go, a society which in its complexity and its increasing material comfort has left him behind. In taking up the use of drugs the addict is merely exhibiting the outermost aspects of a deep-seated alienation from this society, of a combination of personal problems having both psychological and sociological aspects.

The fact that addiction is bound up with the hard core of the worst problems confronting us socially makes it discouraging at the outset to talk about "solving" it. "Solving" it really means solving poverty and broken homes, racial discrimination and inadequate education, slums and unemployment. Nevertheless, we at the Federal level can be doing a great deal more than we have done in the past, both by making the Federal criminal law relating to addiction into as realistic and effective a tool as possible, and by providing a program of Federal aid to encourage more extensive research and treatment efforts around the country. That is why I am so delighted, Mr. Chairman, that you are holding these hearings, and that is why I am so eager to get fast legislative action on the proposals which are before you this morning.

You have a number of bills before your subcommittee. They fall into three categories. Ten of them are bills providing for a Federal civil commitment program. These are parallels of S. 2113, which Senator Javits and I and others introduced on June 9. Three others are the administration bill on narcotics. Finally, there is H.R. 9051, which is Mr. Celler's omnibus narcotic bill. This bill combines, with a few modifications, all four of the bills that Senator Javits and I introduced on June 9—S. 2113, S. 2114, S. 2115, and S. 2116. For convenience, I shall direct my remarks primarily to H.R. 9051, and to H.R. 9167, the administration's narcotics bill, which Mr. Celler also introduced.

I. CIVIL COMMITMENT

Section 1 of H.R. 9051 corresponds to the civil commitment bill which Senator Javits and I introduced on the Senate side. Title I of H.R. 9167 contains the administration's civil commitment proposals.

Mr. Celler's proposal in H.R. 9051 differs from our S. 2113 only in the enumeration of those who are excluded from invoking it. Mr. Celler would make civil commitment more broadly available, refusing it only to persons "charged with knowingly selling narcotics to another

for purposes of resale." S. 2113 contained three more exclusions, including the pendency of a prior felony charge, two or more previous felony convictions, and two or more previous civil commitments. The administration's proposals would except even more persons.

As a personal matter, I favor the broadest possible coverage, the fewest possible exclusions. In this connection, I might call to the committee's attention the comments of Mr. Richard A. McGee, administrator of the California Youth and Adult Corrections Agency which handles California's excellent civil commitment program, about the exclusions from eligibility for civil commitment in S. 2113. For convenience, if the members of the committee do not have S. 2113 before them, they may wish to refer to H.R. 8909, which is Mr. Farbstein's bill. Section 2(c) on page 3 contains the four exclusions. Mr. McGee does not question the first two. These are the exclusion of persons charged with knowing sale for resale, whom Mr. Celler also excludes, and the exclusion of persons against whom a felony charge is pending. Regarding the exclusions for previous convictions and previous civil commitment, Mr. McGee questions their wisdom. He says:

> Narcotic addicts become addicts young—usually before they are 20 years of age. They are arrested and convicted of both petty and felony offenses numerous times in the first few years of addiction. These two exclusions, especially subsection (3), will eliminate practically all of the addicts in the country. Also, it is our experience that some of these persons who have had as many as four or five previous convictions and have grown older in years respond to the program better than some of the younger persons earlier in their careers.

Mr. McGee's views have equal application to the administration's bill. I join in these views.

I should like now to turn briefly to some of the differences between the civil commitment aspects of H.R. 9051 and the civil commitment aspects of the administration's bill. H.R. 9051 makes civil commitment available only to persons "charged with a violation of a Federal penal law relating to narcotics." The administration bill makes it available to persons "charged with an offense against the United States."

Were we a State legislature, this difference would be of major significance. As Mr. McGee points out in the letter which I just mentioned, "Far more drug addicts are arrested for property crimes than for the violation of the narcotic laws." At the Federal level, as we all know, there are few property crimes, so that the difference between the two bills on this score is not significant. Nevertheless, I might say, again as a personal matter, that I prefer the approach of the administration bill. This legislation may well turn out to be a model for new State efforts, and I would not want to see such a State commitment program limited only to persons charged with narcotic violations.

Without commenting specifically on the rest of Mr. McGee's recommendations regarding S. 2113, I ask, with the approval of the chairman and the members of the committee, that his letter be inserted in the record, so that the committee may utilize his suggestions in considering both the House counterparts of S. 2113 and the administration's proposals regarding civil commitment.

Mr. ASHMORE. We will be glad to have it in the record.

(Mr. McGee's letter follows:)

STATE OF CALIFORNIA,
YOUTH AND ADULT CORRECTIONS AGENCY,
Sacramento, July 7, 1965.

Senator ROBERT F. KENNEDY,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR KENNEDY: I am pleased to note that bills have been introduced aimed at a more enlightened approach in the treatment and control of narcotic addicts.

In response to a letter from you dated May 1, 1965, I wrote on May 11 commenting chiefly on your testimony before the New York Senate Committee on Mental Hygiene.

California has had a civil commitment procedure for addicts since October 1, 1961. Because of defects in the act, it was redrafted in 1963. Amendments have been made to it again in the 1965 session. I mention this only to emphasize the fact that we have now gone through 3 years and 9 months of pioneering experience involving the organization of a completely new and different program—a program which we now think is working well.

With this experience, I therefore address myself to S. 2113 and suggest that, in its present form it will encounter difficulties in practice.

I make the following points:

Point 1

On page 2, section 2, beginning on line 5, the bill limits the application of this procedure to * * * any person charged with a violation of a Federal penal law relating to narcotics * * *." This is an unfortunate limitation because far more drug addicts are arrested for property crimes than for violation of the narcotic laws. Therefore, it seems to me that the words "relating to narcotics" should be stricken. Other language should be added after the word "magistrate" in line 8, such as "if the court has reasonable cause to believe that the person is addicted to narcotics * * *."

Point 2

I note, also, in section 2 that the prosecution of the criminal charge against such a person shall be held in abeyance if he elects to submit to an examination and treatment if he is a narcotic addict.

It is our practice in California to proceed with the prosecution or to accept a plea of guilty and at this point adjourn the proceedings before the imposition of sentence. Unless this is done, the court may find itself attempting to try a case 3 years later when the witnesses have died or disappeared, memories are dimmed, and evidence lost. If the fact of guilt is established as soon after arrest as possible and the civil procedure interposed and the person subsequently reverts to addiction or crime or proves incorrigible, the imposition of the sentence upon return to court becomes a relatively simple and straightforward matter.

Point 3

There ought to be provision in the act for an immediate examination of all persons charged and who are believed to be addicts. If the addict is uncooperative—and most of them are in the beginning—a lapse of even 2 or 3 days may make it difficult for physicians to make a determination of whether or not a person is in fact a narcotic addict.

Point 4

Section 2(a)(2) provides that the person found to be an addict shall have 10 days following his appearance before the committing magistrate within which to make a choice between criminal prosecution or civil commitment. Our experience here is that if the expected criminal penalty is substantially less than the expected period of confinement under the civil commitment, the vast majority of addicts will choose the criminal commitment; conversely, if the expected or mandatory term for the criminal commitment exceeds the expected period of confinement under the civil commitment, the tendency will be for them to choose the civil commitment. This will have the inevitable result of channeling the worst offenders into the civil program and the better of them in the criminal program. This is exactly the reverse of what should be desired in the public interest.

We believe that the addict should have no choice at this point in the proceedings.

Point 5

The exclusions from the act set forth in section 2(c) seem to be valid as far as subsections (1) and (2) are concerned. However, I question the wisdom of the exclusions in (3) and (4) (lines 20 through 25, p. 3). Narcotic addicts become addicts young—usually before they are 20 years of age. They are arrested and convicted of both petty and felony offenses numerous times in the first few years of addiction. These two exclusions, especially subsection (3), will eliminate practically all of the addicts in the country. Also, it is our experience that some of these persons who have had as many as four or five previous convictions and have grown older in years respond to the program better than some of the younger persons earlier in their careers.

Point 6

Section 4(a), beginning on line 13, page 5 provides that the civil commitment shall be for an indeterminate period not to exceed 36 months. We do not believe this is long enough. This is not to say that the person should remain in the custody of the institution for more than 36 months, but experience has shown that about 70 percent of those released to aftercare supervision revert to the use of drugs within the first year. Our experience also indicates that the optimum median time of confinement in a drug-free treatment institution before first release is about a year, so if such a person remained in the institution for 12 months and 70 percent of them revert to drugs during the next 12 months, there is only 1 year left of the 36 months to return the person to the institution for a second round of treatment and a second period of release under out-patient supervision.

Our law provides for a commitment of 7 years with a minimum of 6 months of institutional treatment initially. There is a further provision that if the person succeeds in maintaining a drug-free and crime-free existence outside the institution for 36 months after release, he may then be returned to court with a recommendation that the criminal penalty not be imposed and the charge dismissed. Under normal conditions this would take about 4 years even if the performance were perfect. Since it will be far from perfect, sufficient latitude should be provided within the original civil commitment for a number of releases and reconfinements and still leave room for 36 months of clean conduct in the community.

Our law further provides that if the person has not completed 36 months of clean conduct after 7 years have elapsed, he may be returned to court and the court may extend the authority of the State to hold him in the program an additional 3 years.

It is our view at this point that a great deal of flexibility should be accorded to the Surgeon General in release, reconfinement, and release again under close aftercare supervision with provision, of course, that the Surgeon General could return the person to court at any time either because of success or because of failure. Section 4(a), subsections (1), (2), and (3), are therefore appropriate except for the point I wish to make next.

Point 7

Section 4(b), line 6, page 6, seems to say that if a person is released from the treatment institution either because the Surgeon General believes that he has been effectively removed from the habitual use of narcotic drugs or because 36 months have passed, that the Surgeon General must then order the person returned to the court in order to again place the person under the custody of the Surgeon General for not more than 2 years for "probationary aftercare." We believe this would be an extremely cumbersome procedure. It would not only glut up the courts but would provide serious logistic problems because the institutions most likely would not be geographically close to many of the courts of commitment.

The aftercare program, in our experience, is the most essential part of the program. I am afraid with this provision in the law a great many of these cases would be released without postinstitutional supervision. Under these circumstances, this program would have no more hope of success than has been had over the past 30 years with the civil commitments at Lexington, Ky., and Fort Worth, Tex.

We believe that an intermediate quasi-judicial body with power to release or return these persons is the best practical answer. We have created by statute a narcotic addict evaluation authority of four members, which may act in

panels of two, to pass upon the recommendations of the director (or here, of the Surgeon General) with respect both to release and return within the 7-year period. This avoids the necessity of returning the persons to court while they are under the management and control of the program. It also avoids the variability of judgment which will inevitably occur among the many Federal district court judges. In addition to this, a board of this kind can be selected because of its special professional knowledge and expertise in dealing with narcotic addicts.

We wonder, too, what administrative resources would be available to the Surgeon General to provide the close post-institutional supervision of these releasees which they require.

Point 8

Section 8, page 8, beginning on line 11, provides that the Surgeon General is authorized to enter into contracts with the States and local government to carry out both institutional confinement, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to the act. I believe this is a wise provision; however, I have little confidence that most of the States are equipped either with institutions, with skilled treatment personnel, or, especially, with persons equipped by experience and training for the aftercare of this difficult group.

I should think that it would therefore be desirable to provide, either in this act or elsewhere, for the establishment of one or two special institutions somewhere in the United States which would provide for the treatment of a limited number of addicts, say 200 or 300 at a time, and that such facilities would be looked upon as training institutions for personnel in this specialized field. The primary function of such an institution would not be the treatment and care of the addicts confined but the training of personnel who could become the administrators, leaders, and clinicians for other Federal, State, and local programs.

Enclosed is a packet of information regarding the California program. If we can be of further service please let me know as we are much interested.

Yours very truly,

RICHARD A. MCGEE, *Administrator.*

Senator KENNEDY. I might say, Mr. Chairman, that while I was Attorney General and Chairman of the President's Committee, I was very impressed with the efforts that were being made in California. New York and California are the two States that have the greatest problem, New York even greater than California; but California is way ahead in trying to deal with the problem, and I might say far ahead of the Federal Government.

Mr. ASHMORE. Yesterday we had testimony that California is doing an outstanding job and probably has a better law than New York. That is the way it looks at the present time anyway.

Senator KENNEDY. I would say that not only are the laws better, but I think the administration and application of the laws are, quite frankly, much better in California.

Mr. McGee has had considerable experience in administering a civil commitment program and his advice may well help your committee in reporting out the best possible Federal civil commitment program.

None of the civil commitment proposals and none of the postconviction sentencing to treatment program proposals before you will ever succeed unless particular attention is paid in their administration to what might be called the human element. I refer particularly to the addict's needs during the aftercare period. And I think that is where we in New York and at the Federal level fall down. Without highly individualized guidance for a long period of time, the former addict is almost bound to slip back and doom our efforts here to failure.

The truth in this observation is demonstrated by a look at the contrast between the effectiveness thus far of the New York and California civil commitment programs, which are the models for the legislation you are considering today.

Mr. Richard Kuh, who helped draft New York's civil commitment law while he was in the district attorney's office in New York City, has charged that the act has not worked well in New York and says this is so because of "the virtual nonexistence of a serious aftercare program." He points out that of 615 addicts accepted by the State department of mental hygiene in 1963, only 15 percent stayed with the program long enough to have the criminal charges against them dismissed, and this figure says nothing about the rate of return of these people to narcotics use. Perhaps New York will be able to do better now that its budget for narcotics activity has finally been significantly increased, but up to now I think it is fair to say that its civil commitment program has been a great disappointment.

Mr. McGee, by contrast, wrote me recently that of the addicts released to outpatient supervision in 1962 in California, 35.5 percent are still in the community both drug free and crime free. This is about seven times better than any previous recorded experience. The reason for this is an intensive aftercare program. California has developed specially trained parole agents who supervise their charges in small caseloads of 30 per agent. This is what has made the difference.

As Roland W. Wood, superintendent of the California Rehabilitation Center, has said:

> The center's program does not stop at the gate. Followup is vital. California Rehabilitation Center agents—working with small caseloads—help addicts find work; they counsel them; supervise their progress, help them bridge the gap to normal constructive community living.

Mr. ASHMORE. Is the California aftercare program under the probational and parole authority of the State, do you know? Or is it a separate setup?

Senator KENNEDY. It is under the general probational and parole authority of the State, which is called the California Youth and Adult Correction Agency. They handle the civil commitment program.

Mr. ASHMORE. Do they handle criminal offense cases, too?

Senator KENNEDY. Yes. Evidently, Mr. Chairman, they are, in effect, the equivalent to our Federal Bureau of Prisons.

The effectiveness of intensive parole and aftercare supervision has been borne out in a number of studies. The New York State Division of Parole special narcotic project, which combined removal of the addict from his community for an appreciable period of time with meaningful aftercare supervision, produced far better results than the Metcalf-Volker civil commitment law has produced so far. The project was begun in 1956, and at the end of 3 years, 35 percent of the 344 parolees involved were still in good standing. At the end of 1962, 24 percent were still in good standing, or had completed their parole.

Mr. George Klonsky, senior parole officer of the Narcotics Offender Treatment Unit in New York State, illustrates the human counterpart of these statistics by quoting the individual reactions of some of those who were involved in the special project. A gentleman by the name of George U, said, "If I had someone to watch over me, I'd keep good conduct [sic]. When I get depressed (in the past) I would go back to drugs except for my parole. I'd be too scared then. If I were on parole longer, maybe, I'd learn more." Edward J. said that after parole he "drifted down." He wished that his parole had continued until he could "stand on my own two feet." Seymour F., who stayed

off drug use after parole, said, "I had a good parole officer who talked to me * * * explained things * * * helped me a lot."

Thus, it will not be enough for us merely to enact a civil commitment law. We must see to it that the aftercare which we provide is intensive and effective. In this connection, I call to the committee's attention another difference between Mr. Celler's bill and the administration's bill. The former provides for up to 3 years of institutional care, with up to 2 years of aftercare thereafter. The administration's commitment period is limited to a total of 36 months. In the letter which I previously inserted, Mr. McGee comments that California allows commitment to continue for a period of up to 7 years. In view of the evidence that an intensive and effective aftercare and parole period is essential. I would suggest that perhaps the administration's 3-year provision is too short. I know the committee will have all the various alternatives in mind when deciding what time period to adopt.

II. POSTCONVICTION SENTENCING AND CRIMINAL LAW REFORM

Both Mr. Celler's bill, in sections 2 through 9 (this corresponds to S. 2114, which I introduced on June 9), and titles II and III of the administration bill provide for certain changes in the Federal criminal law and for a postconviction sentencing-to-treatment program. The idea of sentencing to treatment, I might say, has some connection with California's civil commitment program since that program contemplates that a person will be tried and found guilty of whatever he has been charged with before he will be considered for civil commitment.

There are some differences between the administration approach and our approach which I would like to discuss.

First, the administration treatment program is available only to narcotic addicts, and also excludes the same multiple offenders and so on who are excluded from the civil commitment program.

I prefer the broader approach of H.R. 9051. Since the psychological problems which the addict has are not unique, H.R. 9051 gives both the sentencing judge and the Attorney General the authority to put anyone convicted of a Federal crime into a treatment program, if that seems to be appropriate. The offender need not be a narcotic addict. I think particularly of persons charged with abuses of barbiturates, amphetamines, and other dangerous drugs who might be charged with violation of Federal law, including the new dangerous drug legislation (H.R. 2) which will be signed into law later this morning. Such persons, in my judgment, should also be entitled to the possibility of treatment rather than normal incarceration. I do not feel that the postconviction sentencing to treatment should be confined to narcotic addicts. I am sure that the committee will carefully consider the alternative approach of H.R. 9051 and H.R. 9167 on this matter.

Further, there is much to be said for not limiting the judge's discretion in deciding who to send to the treatment program. As Mr. McGee points out in the letter which I have inserted in the record, the California experience has been that older multiple offenders are sometimes more amenable to the rehabilitation process. Perhaps the administration carries over the same exclusions that it proposes for pretrial commitment because of the fact that its bill creates an entirely new sentencing procedure—an indeterminate sentencing of up to 10 years with a

minimum of 6 months in institutional custody. It may be that this seems too lenient for certain multiple offenders and others.

I wish to emphasize that I have no fundamental quarrel with this new approach, except that its very flexibility seems to have caused its architects to exclude many people who might be helped by its coverage. In H.R. 9051, the approach taken was to work within the framework of existing law, so that the offender would get whatever sentence he would otherwise have gotten but be sent to the treatment program if the judge or the Attorney General thought that was appropriate. Under that approach there would appear to be no reason for excluding whole categories of persons from its coverage. I know the committee will give due consideration to this difference between the two bills and work out what seems to be the best under the circumstances.

Another difference between H.R. 9051 and the administration bill is that the former has a number of provisions which liberalize the no-parole and mandatory minimum sentencing features of existing law in order to give the convicted addict some incentive to rehabilitate himself. The President's Advisory Commission has forcefully expressed the difficulties created by existing law. The Advisory Commission said that existing law has—

> made rehabilitation of the convicted narcotics offender virtually impossible. Those who have dealt with narcotic offenders in the Federal prisons agree that there is little incentive for rehabilitation where there is no hope of parole.

Myrl Alexander, the Director of the Bureau of Prisons, has called the present criminal law "a rather futile and uncivilized way to deal with the narcotic problem." Of course, the administration bill, by creating a new indeterminate sentencing program, also indirectly liberalizes the present strict no-parole and mandatory minimum sentence provisions. But as I have indicated, I would suggest that this program, because of the exclusions it contains, is unavailable to too many. Thus I prefer the approach of H.R. 9051 on this point. If the committee decides to retain the indeterminate-sentencing idea, I would suggest that its coverage be broadened in two ways: by extending it beyond narcotic addicts, and by eliminating the limiting exclusions which it contains. And, of course, retention of the indeterminate-sentencing approach is not mutually inconsistent with providing the kind of direct liberalization of no-parole and mandatory minimum sentence provisions that is contained in H.R. 9051.

H.R. 9051's approach allows a distinction to be drawn between the addict-violator and the major dealer in the severity of the penalty they receive. It eliminates the mandatory minimum sentence for violation of those aspects of the narcotics laws which are contained in the Internal Revenue Code, while retaining the strict prohibitions in the Narcotic Drugs Import and Export Act. In my judgment, this would allow the Department of Justice to make a humane choice of the statute under which it will prosecute a given accused, since most persons who are accused of narcotic violations are theoretically guilty of two and sometimes three overlapping violations.

I would like to suggest that the committee consider one change in H.R. 9051. Section 5(b) of the bill, by amending section 7237(b) of the Internal Revenue Code, eliminates the mandatory minimum sentence for sale or other disposition of narcotics in violation of section 4705(a) of the Internal Revenue Code. The Bureau of Narcotics has

pointed out to me that, since a sale violation can sometimes involve domestically produced synthetic narcotics or morphine or cocaine stolen domestically from legitimate medical channels, there are some extremely serious offenses which are not covered by the Import and Export Act in title 21 of the United States Code, which deals only with illegally imported narcotics.

I would therefore not oppose, and in fact would support, retention of the mandatory minimum sentence for violation of 4705(a) and retention of the prohibition on probation and suspension of sentence for violation of that subsection, the removal of which is proposed in section 6 of H.R. 9051. Persons guilty of violating section 4705(a) for selling domestically produced drugs would at the same time be guilty of other, lesser violations of the Internal Revenue Code, so that the prosecutorial discretion which it is the aim and purpose of H.R. 9051 to create will not be impaired by this change.

Apart from this change, however, I cannot emphasize too strongly my view that the existence of mandatory minimum sentences for almost all violations of the Federal narcotics law makes these laws an inflexible and cumbersome tool which is too often unfair to the minor violator. For example, Warren Olney III, while Assistant Attorney General in charge of the Criminal Division, told of a letter he received from a judge who had before him a defendant found guilty of purchasing two quarter grains of morphine sulfate. The offender was merely an addict. It was a second violation, and a minimum sentence of 5 years was indicated. There was no way out.

I might say, Mr. Chairman, that while I was Attorney General a very, very high percentage of the pardons and the commutations of sentences, particularly, were given to persons serving long mandatory sentences under the narcotics laws. It became quite clear to those who operated the prisons, to me as Attorney General, and also to President Kennedy and later President Johnson, that this was an unfair and unsound way of dealing with this problem. So I think that some changes need to be made. The administration has one approach and Congressman Celler's bill has a different approach. There might be a combination of the two, or after the committee has considered testimony from experts in this field, it might develop a different way to deal with the problem. As I say, I do not think there is any magic formula, any one formula, and there are some problems with everything that has been suggested. But it is my strong feeling, after my experience as Attorney General, that there needs to be a drastic change made in our approach.

Mr. ASHMORE. I think that is supported by a number of others who have testified and who have introduced legislation on that point. They feel there should be more discretion left in the hands of the court rather than mandatory sentences.

Senator KENNEDY. The mandatory sentence provisions radically changed the nature of the Federal prison population. The Bureau of Prisons was particularly concerned about the implications of having so many no-parole violators in custody. It commented critically that—

> This law has serious implications for the future of the Federal prison system * * *. The changes in prison population which will stem from the en-

forcement of this law will necessitate modifications of institution programs in which sound correctional practices may have to be subordinated to the needs of long-term custody.

The provisions of H.R. 9051 eliminate this inflexibility without destroying the law's ability to get at serious violators. This is particularly true when the modification of section 5(b) of the bill which I discussed a moment ago is taken into account. Retention of the mandatory minimums for serious violations also gives the prosecutor the flexibility he needs to encourage the activity of informers. In fact, the provisions of H.R. 9051 probably would improve the law in this respect.

I am confident, too, that the provisions of H.R. 9051 will not impair the efforts of the Bureau of Narcotics and the Department of Justice to prosecute and convict the Vito Genoveses, the Carmine Galantes, and the John Ormentos. What it will do is humanize the treatment of the little people whose names you and I have never heard and would never remember.

I want to say a special word about the differences between H.R. 9051 and the administration bill on the question of marihuana violators. The administration bill makes marihuana violators eligible for parole, whereas H.R. 9051 removes mandatory minimum sentences for marihuana violators entirely. I certainly do not mean to suggest that there is anything good about the use of marihuana or the trafficking in it. But while it is true that the majority of heroin addicts begin on marihuana, it is also true that the vast majority of marihuana users do not go on to use heroin. So many of those who use marihuana, while unwise, are not people who are appropriately dealt with by being thrown into jail and having the key tossed away. After careful consideration, the President's Advisory Committee concluded "that the unlawful sale or possession of marihuana is a less serious offense than the unlawful sale or possession of an opiate." I therefore hope that this committee will sympathetically consider eliminating mandatory minimum sentences for violation of the laws relating to marihuana.

III. FEDERAL AID FOR TREATMENT AND REHABILITATION PROGRAMS

Finally, I should like to turn briefly to the last two aspects of Mr. Celler's bill—the creation of a program of Federal aid for the building and acquisition of facilities and for the provision of treatment and rehabilitation services by States, local communities and nonprofit organizations. These provisions are contained in pages 17 through 44, sections 10 through 32 of H.R. 9051. They correspond to S. 2115 and S. 2116, which Senator Javits and I introduced on June 9.

These provisions have no counterpart in any proposal submitted by the administration, and I am sorry that they do not. In my judgment, while everything that we have discussed up to now is important, we shall never make any headway toward helping the addict and alleviating the narcotic and drug abuse problem until we can engender and facilitiate a nationwide research and treatment program carried on at all levels of government and by as many private agencies as possible.

If the California experience demonstrates anything, it demonstrates that any headway made will be accomplished only by dint of the most

intensive and personal kind of supervision and sympathetic help to the addict who is trying to stay away from drugs and to become a useful member of society.

An effort like this costs money. And there must be trained, competent personnel available to engage in this kind of effort. The facilities and services portion of H.R. 9051 would provide some of the needed money although, in my judgment, it will take much more as the years pass.

Moreover, the policy underlying these sections is to encourage new people to go into research and enter upon a course of training for work in the narcotics field. Time and time again I hear from doctors and psychiatrists who are interested in narcotics that the toughest problem is to get competent people engaged in research and for treatment. I have been told that there are only two researchers in New York City at the present time who were induced to switch their career fields from another type of research into the narcotics area. We need dozens more people like these men, and dozens more projects.

Mr. Isaac Starr of the University of Pennsylvania put the matter very well in a recent letter to me:

> Good research is not one of those things that one can always get by offering money and by passing laws. Research is done by people, and our task is to interest good people * * *. We can help get research started by pointing out the need and assuring the competent people who might be interested that their work would have our moral support, as well as financial support.

This is the challenge that we face. It can only be won by the Federal Government taking the kind of interest which is manifested in the Federal aid program contained in H.R. 9051, and also, in my judgment, in the effort of this committee at the present time, which I think is most impressive.

I might just make two other observations about this program of Federal aid. One is that it contemplates research and treatment in connection with the use of the dangerous drugs. In this sense, it complements the provisions of H.R. 2, which the Congress so wisely passed recently. The other point is that these provisions contain a redefinition of the mission of the Public Health Service hospitals at Lexington and Fort Worth, so that these facilities can become the model sites of demonstration and research in both narcotic and dangerous drug abuse that they ought to be.

I was glad to be able to appear before you this morning. I hope that these comments are helpful to you in your consideration of the various bills which you have before you.

Mr. ASHMORE. Thank you, Senator, for your fine statement. I know you have put a lot of effort and work and study on this matter, and it will be helpful.

The committee is certainly interested in this entire problem and scheduled hearings shortly after the introduction of these bills. I believe the first of the bills were introduced in June of this year.

Senator KENNEDY. That is right.

Mr. ASHMORE. The middle of June. We feel it is something that should be given immediate attention and given thorough consideration by the Congress to arrive at something of value for all of our people on the subject before the year is out.

Your statement with regard to Federal aid, I believe, is in line with Mr. Celler's bill. He requests an appropriation of $15 million, I believe.

Senator KENNEDY. I believe that is correct.

Mr. ASHMORE. That is for a start. It is not adequate for everything that is needed.

Senator KENNEDY. The total for all of the programs will be $22.5 million each year for 3 years.

Mr. ASHMORE. Do you believe or do you think it would be wise to construct new institutions, establish new hospitals?

Senator KENNEDY. Not unless we have these other programs that go along concurrently. I think the easy out and the easy way to say that we will deal with narcotics is to put up a new hospital or some other type of treatment facility. I think our experience has demonstrated quite clearly that that is not effective and successful by itself. Unless we have an intensive and well-developed aftercare program, the mere construction of institutional facilities, in my judgment, is a waste of money.

Mr. ASHMORE. A waste of money?

Senator KENNEDY. Yes, sir.

Mr. ASHMORE. It would probably be wise, would it not, to use some State institutions or private institutions in collaboration with the work by the Federal Government?

Senator KENNEDY. If we have the overall program, Mr. Chairman, I think that is what is important. To construct a hospital or even use the facilities that are already available without an intensive aftercare program to work with the addicts, is insufficient. For instance, the number who have returned to addiction after having been sent to Lexington and had treatment there is over 90 percent. There has been no meaningful aftercare program available in connection with treatment at Lexington.

Mr. ASHMORE. We had testimony yesterday, which was really amazing, that 90 percent of those released from Lexington or Federal institutions have within a relatively short period of time returned to the use of narcotics.

Senator KENNEDY. I mentioned in my testimony that the program in California has been so effective because they have been able to save 35 percent of the people. Even with that, we are obviously not doing as well as we might. It seems to me that if we really want to deal with this problem in a realistic and effective way, we have to come up with an overall program, and I think the legislation being considered by this committee does that. There may in fact be other things that should be added to it.

President Kennedy was extremely interested in the problem. That is why he called the Narcotics Conference, and that was the first time this kind of a conference of groups from all over the country had ever been brought together. Out of that conference the Advisory Commission was formed under the chairmanship of Judge Prettyman, and they studied the problem very carefully. They have come up with some recommendations. I think, based on the recommendations and based on the conference, we are now in a position where we have enough facts to move on this matter. This legislation that has been introduced by the administration and by all of us, both those on the

committee and some of us in the Senate, is based on fact and experience and, therefore, makes sense.

Mr. ASHMORE. Are you familiar enough with the aftercare programs of New York and California to know just what differences there are in the two State programs?

Senator KENNEDY. In my judgment, Mr. Chairman, the major differences have been in the practice and application of the programs. There has just not been the aftercare effort in the State of New York that there has been in the State of California. In New York there was no real effort to administer the law once it was passed. It was almost felt that all that was necessary was to pass the legislation. From then on not nearly enough was done. The funds appropriated to implement it were insufficient until this year, and we shall have to see whether this year's appropriation turns out to make a difference.

Mr. ASHMORE. Has New York done anything to remove these people from their old environment after they are released? It appears many of them go back to the same friends and neighborhoods and they are soon doing the same things their friends and neighbors are doing and which they had formerly done.

Is there any effort to put them in a different community and get them away from their old friends?

Senator KENNEDY. There has been some, but not nearly enough. Of course we don't really know whether the most effective way to conduct an aftercare program is through intensive supervision of the former addict once he goes back to the old neighborhood, to enable him to adjust, or through a program which separates him from his old haunts for a long period of time while he receives psychiatric help and job training. It seems to me that both approaches should be tried.

Mr. ASHMORE. It appears to me that would be something that could and should be done.

Senator KENNEDY. There is some research and experimentation going on in New York in connection with these things. More research of this type could be very, very important, as suggested in the bill.

Mr. ASHMORE. I agree with you.

Mr. GILBERT. I thank the Senator for appearing here this morning to give us his advice. He has given a great deal of thought to the legislation, evidently.

I agree wholeheartedly a better approach is in the Celler approach than in the administration bill as offered.

I was most gratified for the colloquy between the chairman and yourself regarding the aftercare program. As a Congressman from the city of New York, and in the area that I represent, I probably have as high a percent of drug addiction as any other Congressman in the country——

Senator KENNEDY. I think that is true.

Mr. GILBERT. I have been interviewing these people consistently, and discussing the problems with their families. I find the medical aspect in the criminal approach is one phase in the problem. We can give them all the medical care in the world, and we can remove the stigma of criminality, and yet if they return back to their old environment, they are going to slip right back to where they started from.

I am very curious in view of your experience in the Attorney General's Office if you know of the activities in the various States where

they would be prepared to accept an aftercare program such as you envision in your discussion here this morning.

Senator KENNEDY. I did not quite understand the question. Did you say, are there States——

Mr. GILBERT. Are there States that would accept an aftercare program?

Senator KENNEDY. I think there are.

Mr. GILBERT. I would imagine California and New York.

Senator KENNEDY. Yes.

Mr. GILBERT. I have never heard about Illinois and Pennsylvania.

Senator KENNEDY. Of course, New York has the greatest problem, as I pointed out earlier. New York City has most of that, and your district has much of what New York has.

Mr. GILBERT. That is right.

Senator KENNEDY. California is the State that has the second greatest problem, about 50 percent of what New York has.

I must point out, California is the one that is most advanced in knowing how to establish an aftercare effort as part of its program. If we had the stimulation of Federal legislation, I think New York would make the same kind of effort. There are men of good will in New York who would like to do more than has been done.

Mr. GILBERT. All the Federal legislation in the world that would be passed would be meaningless unless the States do an effective job, and I am hopeful the States will cooperate.

Senator KENNEDY. I would say the increase in the appropriation for this problem which New York has provided for the first time indicates a greater interest.

Mr. GILBERT. Yes. Do you envision that the States will make a financial contribution toward the facilities aspect of the program?

Senator KENNEDY. That is correct; yes. But I think they need the stimulation of Federal matching grants.

Mr. GILBERT. It is my reading on this subject that not too many of the States outside of the big States have really interested themselves in the problem.

Senator KENNEDY. I agree. The big States are where the problem is, basically. And if we can deal with the problem in our own State of New York, the country would be rid of approximately 50 percent of the problem. I think we are to blame to some extent. I think if New York, California, and Illinois, and Michigan gave some direction, together with the Federal Government, we would make tremendous progress in the field. I might say that under this legislation the States are required to participate. It provides for matching funds, two-thirds Federal and one-third State or local.

Mr. ASHMORE. How about the District of Columbia? Would you include it with the large States?

Senator KENNEDY. I do not know what the figures are.

Mr. ASHMORE. I think they have quite a problem here.

Mr. GILBERT. I would like to return to this question of aftercare. Do you envision the addict, or whatever we are going to call him, turning back to his old environment, or do you envision there will be separate institutions, places set aside for him so he could return after he is released.

Senator KENNEDY. I think both approaches should be developed. Of course return to the old environment must be accompanied by the

provision of aftercare supervision, or the former addict will slip back. But we need to learn much more about what overall approach is the more effective.

Mr. GILBERT. To me, the aftercare is more important almost than the treatment.

Senator KENNEDY. Yes.

Mr. GILBERT. It is like the dog chasing its tail. In the event he does not return to a proper supervision and environment, he is going to slip right back.

Senator KENNEDY. That is correct.

Mr. ASHMORE. I have been informed the Senator has an appointment in the White House. He will have to leave in a couple of minutes. I do not want to cut you off, or any of the members. I would like to ascertain whether or not the members would think it necessary for the Senator to come back this afternoon, or sometime that would be convenient to him, if they want to question him. What are your desires?

Senator KENNEDY. I could stay for another 10 minutes.

Mr. GILBERT. Do you envision in your bill some adoption of the English system?

Senator KENNEDY. It does not, except that the idea of maintenance on a synthetic narcotic like methadone might be tried on a limited, experimental basis with carefully selected groups of addicts. But I must say that I do not think the so-called English system holds much promise for helping the great majority of addicts. What this bill does is provide money for all types of treatment programs so we can make further findings and decisions, but it does not put the English system into effect in any significant way.

Mr. KING. I am quite in sympathy with your desires to help the youngsters and first offenders and people who, unfortunately, become addicted to the use of drugs.

I am wondering if you agree with the figures that show that over 70 percent of these drug addicts were criminals first and then become addicts later.

Senator KENNEDY. I believe that is correct.

Mr. KING. So it is going to be difficult for us to weed out the person who is an addict and then unfortunately becomes a criminal in order to feed his desire from the man who is the criminal first and then, when he has not anything else to do, he sinks so low he becomes an addict.

Senator KENNEDY. The proposed legislation has built-in safeguards. If a man is civilly committed and does not cooperate, then the charge against him is to be reinstated. If he does not cooperate, I think he should be punished under the law that he violated in the first place. But I want to reemphasize my basic belief that if the charge is, for example, possession of narcotics, and it is clear he is an addict but not involved in the major sale of narcotics, then I think the man is sick. I think what we are interested in is dealing with the sickness part of it.

Mr. KING. In addition to any punishment he might deserve?

Senator KENNEDY. I am not suggesting that if he is guilty or responsible for the commitment of a crime or that he go unpunished just because he is an addict.

Mr. KING. Many of these people do not become addicts until they are multiple offenders.

Senator KENNEDY. I think there has to be discretion with the judge and prosecutor, and I think that is what the attractiveness of the bill is—there is some discretion on these matters and the individual would not automatically be treated as a criminal and sent off to prison as if he was a Vito Genovese.

Also, if we are going to try to deal with the addict, we must understand that it is not sufficient that he just be sent to a hospital. We might assuage our consciences, but there has to be some effort to follow up on him to find out whether he will stay off narcotics or not. I think that is really the philosophy behind this legislation.

Mr. SENNER. I would like to praise the Senator for his fine statement.

Chairman Celler, testifying in support of his bill, as distinguished from H.R. 9167, the administration bill, indicated to the committee that his bill was broader and would be more effective in handling the problem of the narcotics addict. Do you agree with that?

Senator KENNEDY. As I said in my testimony, I do agree generally with Chairman Celler's approach, although there are some aspects of the administration's bill which I do think are better. Of course, the Celler bill is similar to the ones I first introduced. Congressman Celler also introduced the administration bill that I cosponsored in the Senate. I think it is going to be up to this committee to study both bills and resolve the differences. I tried to point out some of the differences, and the areas where I thought Congressman Celler's approach was superior to the administration's approach. I think the committee will be in the best position to judge that after they have heard the discussion on all these matters.

Mr. KING. As I understood the testimony of Chairman Celler, he recommended that the Narcotics Division of the Treasury Department be under the jurisdiction of the Department of Justice and the Surgeon General in the handling of the drug addict and the rehabilitation stages.

Do you recommend such a change in view of the fact that the present Attorney General testified that he did not want to accept this responsibility?

Senator KENNEDY. I know the President's Advisory Commission also recommended that the Bureau of Narcotics be brought under the Department of Justice. I am opposed to it. I think they have done an outstanding job under the Treasury Department and I have always been opposed to it being transferred to the Department of Justice.

Mr. SENNER. You take the present Attorney General's position? He is also opposed to it.

Senator KENNEDY. That is a good way to describe it.

Mr. HUNGATE. The two bills seem to have a difference in defining people who would be eligible. The Celler bill says in line 4 of page 2 ". . . any person charged with a violation of a Federal penal law relating to narcotics . . ."

Whereas the administration measure says "eligible individual" would mean any individual charged with any offense against the United States. Then it excludes certain offenses.

Senator KENNEDY. Yes.

Mr. HUNGATE. I want your views on those two sections.

Senator KENNEDY. As I mentioned in my testimony, as far as the Federal Government itself is concerned, I do not think there is any great difference as a practical matter between making it available to persons charged with any offense and limiting it only to persons charged with narcotics offenses. Either approach would be satisfactory. I think, however, as I said, that Federal legislation might very well be a model for the States. This will be extremely serious as far as the States are concerned. Therefore, if we take that into consideration, I would take the administration bill approach on the basis that this might be a model for the States and it would be better if they follow the idea of making it available no matter what offense the addict is charged with.

Mr. HUNGATE. The Celler bill approach related to narcotics. I refer to page 2 of H.R. 9051, line 4, and page 3 of H.R. 9167 at line 18.

Senator KENNEDY. Let me get the language from my statement on this point.

Were we a State legislature, this difference would be of major significance. As Mr. McGee points out in the letter which I just mentioned, "Far more drug addicts are arrested for property crimes than for the violation of the narcotic laws." At the Federal level, as we all know, there are few property crimes, so that the difference between the two bills on this score is not significant. Nevertheless, I might say, again as a personal matter, that I prefer the approach of the administration bill. This legislation may well turn out to be a model for new State efforts, and I would not want to see such a State commitment program limited only to persons charged with narcotic violations.

Mr. HUNGATE. In the event States adopt them, it would be a broader coverage?

Senator KENNEDY. That is correct.

Mr. HUNGATE. As far as the Federal Government is concerned, because of the small number of property crimes, it would not matter too much actually as far as the Federal Government is concerned?

Senator KENNEDY. That is correct.

I might say as far as the exclusions are concerned, which is also a part of this question, I would favor the Celler approach.

Mr. HUNGATE. Fewer exclusion once you decided that the offenders were covered.

Senator KENNEDY. Yes. For part of it I would favor the Celler approach, and for that particular language, I would favor the administration approach.

Mr. GRIDER. First, I want to thank you for appearing. It is what one would expect as a graduate of the University of Virginia Law School.

Senator KENNEDY. Thank you.

Mr. GRIDER. I note from your testimony that you favor a more liberal approach to the treatment aspects of our law. I take it you favor treating all criminals with psychological problems as a special category with treatment after the sentence is served, or as part of the sentence; am I correct in that?

Senator KENNEDY. As part of the sentence, let me say. I suppose every criminal might have some psychological problem.

Mr. GRIDER. That is what I was going to ask you.

Senator KENNEDY. I am not suggesting that someone who is a major dealer in narcotics and a pusher of narcotics, or an importer of narcotics, not be prosecuted to the fullest extent of law.

As I say, regarding the Vito Genoveses, I am in favor of retaining the existing sentencing structure for individuals of that kind. As you know, they received sentences of some 40 years in the penitentiary, and I am in favor of that. What I am concerned about, and what I think the committee is concerned about, is not that kind of person or individual, but the individual who gets stuck on narcotics and cannot get off. What are we going to do about him? That is a different kind of problem.

Mr. GRIDER. It is only the narcotics-related criminal that you are concerned with in this testimony?

Senator KENNEDY. Some of them are ill and if they are found to be ill we should take that into consideration in how we deal with them. I do not think we have done that. They should not be turned out on society. I believe they get back into difficulty. I think if we could develop a program where they could be helped, it would make more sense for all of us.

Mr. GRIDER. One final question.

Have you looked into the availability of facilities to give this kind of treatment that these laws provide?

Senator KENNEDY. Yes.

Mr. GRIDER. Do you believe the facilities are available?

Senator KENNEDY. To a large extent. I do not think we need to build a great many new facilities in the sense of new bricks and mortar. We need adequate treatment programs and services to go with the facilities, and we need to build or acquire some facilities as well.

Mr. ASHMORE. Can you return this afternoon? The members on my right have some questions.

Mr. MCCLORY. I would confine mine to one question.

Senator KENNEDY. It would be more convenient if we can do it now.

Mr. MCCLORY. I noticed as a Representative from the State of Illinois—actually Illinois has the second largest problem—and having had some experience in the State legislature in Illinois in increasing the penalties, and noting too that Illinois has made the highest percent of progress with regard to the reduction of active narcotics addiction, I wonder about the wisdom of greater flexibility in minimum sentences. It was my experience this was a discretion greatly abused by the courts, depending upon who the defendant in the case was. There has been great progress as a result of establishing higher minimum sentences and greater penalties.

Senator KENNEDY. Again, what I am trying to do—and what I think we all have to do—is to separate this group into two separate categories: One are the people who live off of narcotics, who push narcotics and make a living off of it. I have no reservations about giving them the maximum sentence, and I am not in favor of changing that. But there are those others who just become addicted to narcotics and cannot get off and, therefore, should be treated in a way other than sending them to prison for 5 years and letting them out.

In my judgment, based upon my experience as Attorney General, and upon the experience of the Bureau of Prisons, we should handle them differently. We should say, "If you will undertake this institutional treatment, and this aftercare treatment, we are going to deal with you in a different way than just sentencing you to prison." That is the idea.

Mr. McCLORY. As far as the distinction is concerned between these two types of cases, we should make the distinctions as accurately as we can by legislation and not delegate that authority to a court.

Senator KENNEDY. Yes. Of course, it exists now with any prosecutor.

As I pointed out in my statement, almost invariably an individual who is arrested is guilty of two, or possibly three, different Federal crimes. The prosecutor must determine under what section of the law he is going to prosecute. If he finds he is a pusher and he is one of the importers of narcotics and that is the way he makes his living, he could be prosecuted under the Export-Import Act. That is what we prosecuted Vito Genovese under. In my judgment, that is the way we should proceed. Other people we should deal with differently. But I am not in favor of letting everyone out of prison.

Mr. ASHMORE. Thank you very much, Senator.

Senator Javits, we are glad to have you.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. Thank you. I certainly appreciate the opportunity to appear and will endeavor, insofar as humanly possible, not to duplicate what I have already heard of the testimony of my colleague, Senator Kennedy.

Mr. Chairman, the Nation is at least, with these hearings, beginning its awakening to the grave national problem of drug addiction, its relationship to the growing crime rate, and its corrosive effect on our urban society.

In order to establish my qualifications in this field, Mr. Chairman, let me point out that my experience dates from my incumbency as attorney general of the State of New York, when I organized the first governmental conference to consider what ought to be done about narcotics addiction. The conference was chaired by Oren Root, of New York. In that capacity, I was also Chairman of the State Attorney Generals' Committee on narcotic addiction, and developed with the attorneys general of the States the concept of medical treatment for narcotic addicts who had been convicted of crime. So I come to this particular position by a somewhat different route from that of my colleague, Senator Kennedy, who was Attorney General of the United States. We have joined together in introducing four narcotics measures in the Senate.

I am deeply gratified Chairman Celler of the parent committee has done us the honor of hearing this testimony.

May I say, by way of supplementing what Senator Kennedy said, that I would strongly favor the Celler bill over the administration bill as a framework for legislation here in the House, but I see no reason why the administration bill may not be drawn on to buttress and support the fundamental thesis of the Celler bill.

I believe that the fundamental difference is that the administration bill in its terms would make medical treatment under civil commitment available to somewhat broader categories of persons. In listening to the questions from the members of the committee, it occurred to me that the proper distinction was this: The offer to the addict of volun-

tary opportunity to obtain treatment should properly be confined to the addict charged with a narcotics offense not equivalent to the offense of being a dealer.

For that purpose I would accept the definition in the administration bill of a dealer, that is, a person selling other than primarily for the purpose of satisfying his own addiction. Other addicts should be allowed to choose medical treatment under civil commitment in lieu of standing trial. Beyond that category, it should be at the option of the Federal Government, that is, the Federal court with a recommendation from the prosecution, whether or not the person charged will be permitted to choose civil commitment for treatment rather than stand trial and serve his time in an ordinary sentence.

It seems to me that is a clear and logical distinction, which could be accomplished by amalgamating the definitions in the Celler bill with those in the administration bill. In all other respects, I very strongly favor Congressman Celler's bill, which I think embodies a much broader program and is much more deeply based upon the experience in New York and in California which Senator Kennedy touched upon.

For many years I and others in the Congress have sponsored bills to reform the harshly punitive and ineffective Federal approach to narcotic addition. A significant consensus for reform has been developed among the experts. Finally, the administration has come forward with a proposal. While I applaud the fact that the administration has at last begun to move in this neglected field, I regret that its proposal falls short of meeting squarely the urgent need to treat narcotics addiction—as distinct from the commercial exploitation of addiction—as an illness, rather than as a crime.

In two respects the administration proposal, H.R. 9167, would make a significant step forward along the lines of the pioneering California and New York laws, by authorizing civil commitment for medical treatment and rehabilitation in lieu of criminal prosecution for narcotics addicts, and by easing existing rigid restrictions on postconviction sentencing so that addict convicts can be medically treated and rehabilitated. In these respects the administration bill closely parallels two of the four bills, S. 2113 through S. 2116, which I introduced this session in the Senate with Senator Robert F. Kennedy and a bipartisan group of cosponsors. A host of bills identical to ours were introduced in this body, beginning with H.R. 8877 through H.R. 8880, introduced by Congressmen Harris, Mills, and Reid of New York; and I am most gratified that the entire series of four bills has been introduced as H.R. 9051 by the distinguished chairman of this committee, Congressman Celler, and is before this committee.

However, in two major areas the administration bill fails to meet the standard set by the bills which so many of us in both Houses have introduced: It lacks a Federal program of construction of needed facilities for medical treatment of addicts; and it lacks a Federal program for providing postmedical treatment services to addicts.

This is a crucial gap in the proposed legislation, for most experts agree that, once the courts have the authority to make medical treatment and rehabilitation available to addict defendants, there must be adequate facilities to receive and treat them. There is no question about the inadequacy of the two Federal facilities which now exist, particularly to meet the basic need—which, again, the experts affirm—

for a long period of aftercare in the addict's home environment, including a wide range of services—psychiatric, medical, job counseling, work training—in a wide variety of facilities—halfway houses, sheltered workshops, outpatient clinics.

I strongly urge the committee to remedy this lack by reporting favorably H.R. 9051, which contains the medical treatment programs of our bills, S. 2115 and S. 2116.

Other lesser differences exist between the administration's proposal and ours. I ask unanimous consent that a memorandum of those additional differences may be made a part of my remarks, and I submit them for the record.

Mr. ASHMORE. Without objection.

(The memorandum referred to follows:)

MEMORANDUM OF ADDITIONAL DIFFERENCES BETWEEN H.R. 9051, INTRODUCED BY CONGRESSMAN CELLER, AND H.R. 9167, THE ADMINISTRATION BILL

(1) Eligibility for civil commitment: (a) The administration bill purports to offer a commendable extension of eligibility by including addicts charged with any Federal offense, not solely a narcotics offense. But the impact of this provision is diluted by making an exception of the crimes against property, which are most often committed by addicts—burglary, robbery, and housebreaking. (b) The other disqualifications in the administration bill are similar to those in my bill, S. 2113, and do not appear in the Celler bill. Excluded from the former bills are those twice convicted of a felony, twice civilly committed, awaiting disposition of a felony charge, or serving sentence from a felony conviction. I regard these as important disqualifications to insure that civil commitment is offered only to those likely to benefit from it.

(2) Time for Surgeon General's examination: The administration provision for an examination period of up to 60 days—six times longer than our examination period—raises the questions of whether so much time is necessary to determine addiction and whether due process would be denied by so long a confinement if it is not necessary for that purpose.

(3) Appeal from Surgeon General's finding: H.R. 9051 allows a hearing for the defendant if he wishes to contest the finding as to whether he is an addict. The administration bill affords no appeal, thus depriving the defendant of the opportunity to elect civil commitment if the Surgeon General is in error.

(4) Eligibility for postconviction sentencing to treatment: Our bill would allow any convicted addict or person with a mental or physical condition to be sentenced to institutional care and thence significantly extends the availability of treatment. The administration bill falls short by excluding the same classes of offenders it would make ineligible for civil commitment.

(5) Treatment of offenders under age 22: Although present law does not explicitly prohibit the application of the flexible procedures and the specialized sentences of the Federal Youth Corrections Act to narcotics violators under 22, judicial decisions have imposed such a prohibition. I feel that the specific extension of the Federal Youth Corrections Act to cover all narcotics offenses, made in our bill and not in the administration version, would overcome any uncertainty on this score.

(6) Sentencing provisions: H.R. 9051 would allow needed flexibility in sentencing by eliminating the present mandatory minimum sentences for violations of the narcotics provisions of the Internal Revenue Code, and by easing the ban on suspended sentences, probation and parole in narcotics cases, while retaining the full severity of penalties under the Narcotic Drugs Import and Export Act. The administration bill would allow parole only in marihuana cases and would leave untouched both the mandatory minimum sentences and the limitations on the granting of suspended sentences and probation. The administration bill would thus deprive the courts of discretion to distinquish between large-scale peddlers and addicts amenable to treatment.

(7) Return to institutional care: The administration bill has improved at least in this respect on the Celler proposal by specifically providing that the Surgeon General may order an addict under probationary aftercare to return to institutional treatment.

Senator JAVITS. I think I have pointed out the salient differences. I would like to make one or two other points in response to points made by Senator Kennedy.

In the first place, there is now an enormous body of opinion which backs the fundamental approach taken by the Celler bill. The fundamental concepts were generally supported by the American Medical Association and the American Bar Association in their joint report in 1959 by the AMA and the National Research Council in a statement by the New York Academy of Medicine, and by the National Advisory Council of Judges of the National Council on Crime and Delinquency. Then, of course, there are the basic recommendations of the White House Conference on Narcotics and Drug Abuse, and the implementing recommendations of Judge Prettyman's committee.

I think it is significant that in the Senate we have had in two committees recommendations which indicate the need for a complete overhaul of our methods of dealing with this problem. One was a recommendation by the Senate Permanent Subcommittee on Investigations, of which I am a member, in its report issued in March 1965 following extensive hearings in 1964 on narcotics traffic. And the Senate Judiciary Committee received a report in April 1962 from the Department of Justice, at that time headed by then Attorney General Kennedy, in which for the first time the civil commitment idea for rehabilitation and treatment was espoused by the Department in commenting on bills which I had introduced.

So I think the backing, the consensus which has been arrived at in the Nation for these changes, is now extremely strong.

Now, a word about the program in the States, to which Senator Kennedy referred. Mr. Chairman, I placed in the Congressional Record of June 9, 1965, when Senator Kennedy and I introduced our bills, an analysis of the treatment programs of New York and California which may be of interest to the committee.

Mr. ASHMORE. We would like to have it in the record.

Senator JAVITS. I ask that pages 12574 through 12588 of the Record be inserted.

(The pages referred to follow:)

LEGISLATION TO COMBAT NARCOTICS ADDICTION

Mr. GRUENING. Mr. President, I yield to the Senator from New York, without losing the floor.

Mr. JAVITS. Mr. President, I ask unanimous consent that I may introduce two bills, and then yield to my colleague from New York, Mr. Kennedy, and to the Senator from New Jersey, Mr. Case.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JAVITS. Mr. President, pursuant to prior agreement with the Senator from New York, Mr. Kennedy, we are introducing a series of bills to deal with the narcotics addiction problem.

I send to the desk out of order and ask unanimous consent that there be referred two of the four bills.

These measures are part of a four-bill series of legislative proposals on this subject of vital importance to our urban areas, which I am most pleased to introduce jointly with my colleague from New York, Mr. Robert F. Kennedy, along with a bipartisan group of cosponsors, including Senators Case, Ervin, Hart, Kuchel, Tydings, and Williams of New Jersey, who are cosponsoring all four bills; Senator Saltonstall, who is cosponsoring the two involving civil commitment and sentencing of narcotics addicts; Senator Scott, who is cosponsoring the civil commitment bill, and Senator Long of Missouri, who is cosponsoring the two medical treatment bills.

Also introducing the measures in the House of Representatives are Congressmen Reid and Lindsay, of New York, who have long championed such an enlightened approach to this subject in the other body, along with Congressman Bell, Delaney, Mathias, McCulloch, Ottinger and Springer, Celler, Farbstein, and Ryan of New York.

In addition, Congressmen Harris and Mills are introducing some but not all of the measures.

The bills introduced today would:

First. In lieu of criminal prosecution, authorize the pretrial civil commitment, for medical treatment and probationary aftercare, of those charged with narcotics offenses, except for sale with intent to resell, along the lines of the pioneering New York State law. I am the principal sponsor of this bill.

Second. Modify the harsh present postconviction sentencing restriction, so that the Federal courts can use parole, probation, and suspension of sentence as tools to rehabilitate convicted defendants, particularly youthful offenders who are addicts, along the lines of techniques first used in California. Senator Kennedy is the principal sponsor of this bill.

Third. Establish a Federal-State two-thirds, one-third matching grant program to provide a wide range of services, job training, family counseling, and phychiatric treatment to ex-addicts to enable them to reenter the community. Senator Kennedy is the principal sponsor of this bill.

Fourth. Create a Federal-State two-thirds, one-third matching grant plan for the construction or acquisition of needed facilities for medical treatment, especially outpatient clinics for the crucial period of aftercare and adjustment of those who have been taken off narcotics. I am the principal sponsor of this bill.

These measures are the outgrowth of my concern with this problem as attorney general of the State of New York and of a series of bills which I introduced for a number of years along with my former colleague, Senator Kenneth B. Keating. The purpose of this legislation, like that of the measures we introduced in the past, is at last to bring the Federal Government in a position to deal effectively and in modern terms with the grave national problem of narcotic and drug abuse. It is my earnest hope that after years consumed in studies and restudies, conferences and panel discussions, the Congress will recognize that the time for action is now.

For many years it has been painfully apparent that the growing extent of addiction has directly boosted the national crime rate and that its corrosive effect upon the lives of its victims and their families has been increasing drastically and intolerably. It has also become painfully apparent that the Federal law and the Federal approach to the increasingly grave problem are wholly inadequate. As the law now stands, the Federal approach is primarily through a rigid set of criminal laws, which do not differentiate sufficiently between the underworld wholesaler of narcotics and the victim of that system who is found in possession of a small amount of illegal narcotics because he is an addict and in need of medical treatment, both mental and physical. More than 5 years ago the State of California and New York recognized the growing acceptance of the premise that narcotics addiction—apart from organized selling or "pushing"—is a disease rather than a crime. The two States enacted pioneering legislation which placed the primary emphasis upon affording the addict an opportunity to become rehabilitated mentally and physically instead of being punished as common criminal.

I ask unanimous consent that there be printed in the Record at this point in my remarks a summary of the California and New York narcotic programs from the final report of the President's Advisory Commission on Narcotic and Drug Abuse, along with a summary of the New York State budget on this subject for the coming year.

There being no objection, the summaries were ordered to be printed in the Record, as follows:

"CIVIL COMMITMENT

"Probably the most far-reaching new development has been the enactment by California and New York of laws for the civil commitment of narcotic addicts. The California law was enacted and became effective in 1961 and was amended in July 1963; the New York law was enacted in 1962 and became fully effective in January 1963.

"Civil commitment is a legal mechanism utilized in lieu of a criminal commitment to insure control over addicts and potential addicts during rehabilitation, first in an institution, later perhaps in a halfway house, still later in the community under the close supervision of a probation or parole officer.

* * * * * * *

"THE CALIFORNIA PROGRAM

"The present California laws provides for the civil commitment of persons who are addicted to narcotics or who are in imminent danger of becoming addicted. The law distinguishes three categories of persons who may be civilly committed:

"(1) persons convicted of misdemeanors.

"(2) persons convicted of felonies other than crimes of violence, and

"(3) persons not charged with crimes who report to the district attorney their belief that they are, or are about to become, addicted; or who are reported to the district attorney by relatives, friends, or others.

"In the case of those convicted of a misdemeanor or felony, where the judge has reason to believe that the defendant may come under the civil commitment law, further criminal proceedings are suspended after a conviction or plea of guilty, a petition is filed, and a judicial hearing is held. If it is found that the defendant is addicted or in imminent danger of becoming addicted, the court having jurisdiction over the commitment proceedings may commit him to the director of the State department of corrections for a maximum period of 7 years; on a finding that he is not, the court will return him to the court having jurisdiction over the criminal proceedings for sentencing. If at any time after 60 days the director of corrections concludes that a committed defendant is not a fit subject for treatment he is returned to the court having jurisdiction over the criminal proceedings for further disposition.

"In the case of those who are not charged with the commission of a crime, the court having jurisdiction over the commitment proceedings may, after a medical examination and a judicial hearing, deny the petition and discharge the person, or it may order him committed to the director of corrections. If the person voluntarily sought commitment, the maximum period of commitment is 2½ years. If the commitment is involuntary, the maximum period is 7 years. The director of corrections may discharge him if he concludes at any time after 60 days that he is not a fit subject for the program.

"All those who are committed under this law are sent as patients to the California Rehabilitation Center in Corona, Calif., administered by the department of corrections. At the rehabilitaton center, the patient enters upon a group psychotherapy program, and participates in a remedial educational program, vocational training, and other rehabilitaive activities. He must remain at the rehabilitation center at least 6 months before he is eligible for release as an outpatient. After release, he is kept under close supervision by specially trained parole officers. Nalline tests are periodically administered to detect any relapse. If it becomes necessary he may be returned to the rehabilitation center for further treatment and again released under supervision. If a persons who has been committed abstains from the use of narcotics for 3 consecutive years as an outpatient, he may be discharged from the rehabilitation program. If his commitment followed a criminal conviction, the criminal proceedings may be dismissed after his discharge. If a convicted persons is not discharged prior to the expiration of his term of commitment he is returned for further disposition to the court having jurisdiction over the commitment proceedings. The court may extend his commitment for a period not to exceed 3 years or it may return him to the court having jurisdiction over the original criminal proceedings for resumption of those proceedings.

"The California program is reaching a significant number of narcotic abusers. On September 30, 1963, there were 1,121 persons at the rehabilitation center and 601 outpatients. The facilities of the program will be broadened. Additional halfway houses for persons under civil commitment are planned for the northern and southern sections of the State. Finally, it should be noted that research on narcotic abuse and on the efficacy of the civil commitment program is gradually being built into the program as an integral part of it.

"THE NEW YORK PROGRAM

"The New York civil commitment law, popularly known as the Metcalf-Volker Act, provides, like the California law, for both inpatient and outpatient treatment. But where the California law lodges the responsibility for the es-

tablishment and operation of the treatment program with the director of corrections, the New York law lodges it with the commissioner of the State department of mental hygiene.

"Under the New York law there are three categories of addicts eligible for admission to program. The process of commitment, the length of time for which an addict can be held, and the procedures of the program, differ with respect to each category.

"The largest category covers narcotic addicts who have been arrested for narcotic law violations or other criminal offenses, except certain serious crimes, but have not yet been convicted. There must be no extensive history of prior felonies or of failures under prior commitments, and there must be no objection from the district attorney.

"The addict offender must request commitment within 10 days of his arrest. If he does, he may be committed for treatment. The commissioner of mental hygiene must be willing to accept him, and there must be adequate treatment facilities, although treatment need not be wholly institutional. The total period of commitment, however, may not exceed 3 years, whether spent in a treatment facility or in the community under supervision. If the addict offender is committed, prosecution of the original criminal charge is held in abeyance. If in the course of treatment it is found that the addict offender is unresponsive or uncooperative, he is returned to the court. If he completes the treatment program successfully, he is discharged and the criminal charge is dismissed.

"Another category includes narcotic addicts who voluntarily commit themselves to a treatment facility or, if under the age of 21, are committed on application by their next of kin. They may be held without a judicial hearing and given treatment for a period of at least 45 days, and no longer if they consent. Where there has been a judicial hearing, they may be held and given treatment for a period of not more than a year. The addict may be discharged before the expiration of a year if he has recovered or if he is not amenable to treatment.

"The third category covers addicts convicted of a crime, usually offenders placed on probation by the court on condition that they submit to treatment. Again, the commissioner of mental hygiene must be willing to accept the addict for treatment, and adequate facilities must be available. The treatment program need not be wholly institutional and may include outpatient care in the community under supervision. The entire course of treatment cannot exceed the period of probation imposed by the court. The addict may be returned to the court before expiration of the probationary period if he has recovered or if, on the other hand, he is unresponsive or uncooperative.

"The department of mental hygiene has established special treatment units for committed addicts in six State hospitals: one in New York City, three within 70 miles of New York City, and two in upstate New York. These units have a total capacity of 455 beds. Local authorities, especially in the large cities, are expected to provide supplementary facilities for detoxification, and, in some cases, facilities for short-term treatment.

"When an addict is released from inpatient care and treatment in a State hospital unit and returned to the community on an outpatient basis, he is required to report periodically to a facility designated by the commissioner of mental hygiene as suitable to supervise a treatment program for former addicts. Such facilities may be under public or private auspices. In the New York City area, the State department of mental hygiene operates aftercare clinics on Wards Island and on 17th Street. Throughout the outpatient period, addicts are subject to home visits and to reasonable regulation of their conduct by the aftercare facility. They must submit to medical treatment and nalline tests to detect any relapse. The New York civil commitment law came into effect on January 1, 1963. On October 23, 1963, the program had 370 inpatients in the various State hospital treatment units and 285 outpatients."

Budget of the New York State Department of Mental Hygiene for narcotic administration, treatment, and research for fiscal year 1965–66

	Amount	Remarks
1. Administration	$151,485	Includes 15 additional positions principally in professional and technical areas.
2. Treatment services:		
For the operation of 6 treatment units in State hospitals, a total of 500 beds—Buffalo, Utica, Middletown, Manhattan, Pilgrim, and Central Islip.	2,426,096	These have been under operation for 2 years. Includes 60 new positions.
2 additional treatment units, 75 beds each, Bronx and Brooklyn.	754,730	Includes 156 new positions.
New York City After Care Clinic	180,954	This has been in operation for 2 years.
Bronx After Care Clinic	216,735	Includes 23 new positions.
Brooklyn After Care Clinic	205,000	New—Rental of facilities and an estimated 60 positions.
Queens After Care Clinic	205,000	Do.
3. Shared cost of New York City outpatient clinic	100,000	New—50 percent cost.
To New York City Mental Health Board for housing of patients.	450,000	New—100 percent cost.
For assistance of neighborhood groups	300,000	New.
For operation of halfway houses	210,000	Do.
For a sheltered workshop	50,000	Do.
4. Research: Research study, including 55-bed inpatient unit.	539,584	This has been in operation for 2 years.
Total	5,789,584	

Mr. JAVITS. Mr. President, meanwhile the Federal Government has continued to ignore the advice of virtually every expert group in the country as well as the New York and California experiences. It has continued to rely solely upon a 50-year-old, wholly punitive approach to narcotics addiction without any significant regard to identifying, isolating, and treating its social, psychological causes. The Federal experience consists of approximately 800 convictions each year: Only two Federal hospitals—at Fort Worth, Tex., and Lexington, Ky.—deal with the subject, and they register a staggering rate of recidivism.

A long series of expert studies and reports make it abundantly clear that there is a consensus among the medical and law enforcement communities about at least four major, glaring defects in the existing Federal approach:

First. There must be legislation to provide Federal aid to State and local governments and nonprofit private groups for the construction and operation of facilities to provide treatment and rehabilitation programs in the home community of those afflicted. Everyone who has studied the matter agrees that the two existing Federal hospital facilities in their present locations—whatever their intrinsic merit—cannot begin to meet the tremendous need for rehabilitative aftercare, involving a wide range of services—medical, psychiatric, psychological, family counseling, job training—which appear at this point to be the only approach which has a chance of meeting the narcotics challenge.

Second. There must be legislation authorizing Federal civil commitment for the treatment of narcotics users as an alternative to criminal prosecution and imprisonment and there must be some amelioration of the rigid restrictions on the postconviction sentencing in the Federal courts of defendants who are narcotics addicts.

Third. There is a great lack of reliable information about the extent of narcotics addiction and about the proper techniques for achieving permanent cures. Everyone seems to agree that a much greater effort in research must be made by the Federal Government.

Fourth. Finally, there is also general agreement that since narcotics are the product of nations overseas, there must also be a massive effort to achieve effective international control over the illegal distribution and entry of narcotic drugs.

These basic conclusions have been supported generally by such groups as the American Medical Association and American Bar Association in a joint report in 1959, the AMA and the National Research Council in a 1962 statement, the New York Academy of Medicine and the National Advisory Council of Judges of the National Council on Crime and Delinquency.

A White House Conference on Narcotics and Drug Ahuse, which Senator Keating and I had long advocated, was called in September 1962 and formed the basis for the President's Advisory Commission on Narcotic and Drug Abuse, which issued its final report along these lines in November 1963. The Medical Society of the County of New York has added its conclusions of January 1965. And the Senate Permanent Suhcommittee on Investigations in a report issued in March 1965, following 1964 hearings on the illicit traffic in narcotics, also endorsed these hasic conclusions. These distinguished bodies have set the stage for Federal action. The bills Senator Kennedy and I are offering now are designed to achieve that action.

It is noteworthy in this connection that one of the few signs of progress in the Federal Estahlishment was a report in April 1962, to the Senate Judiciary Committee from the Justice Department—which was then headed, as Attorney General, by Senator Kennedy of New York—favoring the civil commitment hill which Senator Keating and I had introduced in the 87th Congress and which is the forerunner of one of the measures which I am introducing with my colleagues today. Writing for the Department, Byron R. White, then Deputy Attorney General and now Associate Justice of the Supreme Court, stated:

"In summary, the bill treats the narcotics problem from an approach which recognizes that the drug addict is a sick person and that in some instances he and society as well would be benefited if he were dealt with initially as such. Since the violation of penal laws is often attrihutable to narcotic addiction, the Department of Justice favors this new, yet limited, approach to the suhject. Accordingly, enactment is recommended."

This approach received a great boost when President Johnson, in his crime message to Congress this year, endorsed a civil commitment measure. I very much hope that the administration will follow through on this by either endorsing the legislation we are today introducing or by introducing legislation of its own. I also very much hope that the Congress will at last act.

The only action which Congress has taken at this point has been in connection with the Mental Health Centers Construction Act of 1963, Public Law 88–164. At my insistence, the conferees on that measure made it clear that the act would permit States to include facilities for some treatment of narcotics addiction within such federally assisted mental health centers. The program authorized hy that act is now just beginning to get underway, and it is unclear as to the extent to which the States will be able to make use of it for the purpose of narcotics addiction treatment. Senator Kennedy and I have inquired of the National Institute of Mental Health and have been advised that New York State is preparing to participate in the program.

One area which has received widespread attention hy the expert groups should be discussed in greater detail. That is the matter of research. The Public Health Service Act, section 303, presently authorizes the National Institute of Mental Health to make up to 100-percent grants to governmental and private, nonprofit agencies for research and demonstrations in the treatment of mental illness. In 1962, the Department of Health, Education, and Welfare advised me that there was little use of this section for research into narcotic addiction in part because the Department was doubtful as to the legal scope of section 303 in regard to narcotics addiction. Accordingly, the legislation which Senator Keating and I introduced in the 87th and 88th Congresses included a measure specifically extending section 303 to cover research into addiction. I have now been advised by the Department that their legal doubts have been resolved so that such legislation is unnecessary.

I ask unanimous consent that there he printed in the Record at this point in my remarks my exchange of correspondence with HEW.

There being no ohjection, the exchange of correspondence was ordered to be printed in the Record, as follows:

FEBRUARY 9, 1965.

Hon. ANTHONY J. CELEBREZZE,
Secretary of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: As you know, I have long been deeply concerned about the need for a medically oriented Federal program against narcotics addiction and have repeatedly introduced a series of measures in the Senate to establish such a program.

One of the key factors, in my judgment, is the present lack of definitive information on how addiction can be effectively treated and resisted after treatment.

For some time I have been convinced that the Federal Government could make a significant contribution to scientific knowledge in this area through section 303 of the Public Health Service Act, which authorizes up to 100-percent grants to State and local, public or nonprofit agencies for research in the field of mental health.

The Public Health Service advised me in 1962 that section 303 funds were very little used for narcotics research, in part because there was uncertainty in the Service as to whether narcotics addiction was legally includible within that program. I then introduced legislation, which was S. 3098 in the 87th Congress and S. 862 in the 88th Congress, which would have made this authority clear and specific.

I am now in the process of reintroducing this legislation and would very much appreciate your giving me at your earliest opportunity up-to-date data on the following points: (1) the extent of the entire section 303 research program; (2) the extent to which it has or is being used for narcotics research including specific data as to the locations and types of projects; (3) the extent to which legal problems have prevented full utilization of section 303 for narcotics research; (4) and the extent to which a lack of funds or a lack of public information about the program or other factors have prevented full use of this section for narcotics research.

Particularly as the ranking Republican member of the Senate Labor and Public Welfare Committee and its Subcommittee on Health, I would very much hope that we may soon be able to take a significant step forward in at last meeting the growing menace of narcotics addiction.

With warm regards.

Sincerely,

JACOB K. JAVITS, *U.S. Senator.*

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 23, 1965.

Hon. JACOB K. JAVITS,
U.S. Senate, Washington, D.C.

DEAR SENATOR JAVITS: Thank you for yonr recent letter concerning narcotics addiction, and inquiring about projects supported through section 303 of the Public Health Service Act. The Public Health Service through the National Institute of Mental Health does support research projects in the field of narcotics addiction under section 303, and a statement from the Service is enclosed.

With kind regards.

Sincerely,

ANTHONY CELEBREZZE, *Secretary.*

Enclosure.

STATEMENT FROM THE PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, WASHINOTON, D.C.

Section 303 relates to mental health project grants (title V of the Health Amendments Act of 1956). It is extremely broad in scope and authorizes the Surgeon General to make grants for investigations, experiments, demonstrations, studies, and research projects, with respect to the development of improved methods of diagnosing mental illness and for care, treatment, and rehabilitation of the mentally ill, including grants to State agencies responsible for administration of State institutions * * * for developing and establishing improved methods of operation and administration of such institutions.

The major focus of the program of mental health project grants has been the support of projects designed to enable experimentation and demonstration of new program ideas, techniques, and evaluation within the mental health field. Projects have been accepted for review on the basis of their relevance to mental health. One of the major strengths of the mental health project grants program has been its flexibility which has enabled it to encompass a broad range of important projects, including addiction, which are related to the overall program of the National Institute of Mental Health. As the program of mental health project grants went through its developmental phase, applications were accepted, approved, and funded that encompassed activities focused on the promotion of mental health and interventions to prevent mental illness; it also became the mechanism through which projects in school mental health, alcoholism, nar-

cotic addiction, mental retardation, delinquency, aging, child mental health, and other program areas received consideration.

Under section 303, grant applications have been received by the National Institute of Mental Health and 11 mental health project grants relative to narcotic addiction will have been completed or will be active at the end of fiscal year 1965. The projects listed below are those supported under section 303. They do not include related studies supported by the NIMH's intramural or regular research programs. As can be seen by the titles the projects include: the analyses of cultural, social, and psychological factors related to the use of narcotics; the determination of critical incidents which lead to a return to the use of narcotics; the effectiveness of community based treatment centers is being investigated in several of the projects; and others provide for surveys of existing treatment programs prior to initiating new ones:

1. MH-00728. "From Gang Violence to Heroin Among Adolescents": The principal investigator is Mr. Edward Preble, assistant professor of anthropology, New York Schol of Psychiatry, New York, N.Y., and the grant is to that agency.

2. MH-0080. "A Halfway House for Narcotic Offenders": The principal investigator is Gilbert Geis, Ph. D., program director, Institute for the Study of Crime and Delinquency, Sacramento, Calif., and the grant is to that agency.

3. MH-00869. "Recreation in Rehabilitation of Narcotic Addicts": The principal investigator is Mr. Elliot G. Young, program director, Comeback, Inc., New York, N.Y., and the grant is to that agency.

4. MH-00918. "Narcotics Addiction Service Center": The principal investigator is Robert M. Slawson, M.S.W., executive director, Narcotics Addiction Service Center, and the grant is to the Stamford Community Council, Inc., Stamford, Conn.

5. MH-01005. "Field Visits To Observe Programs in Narcotic Addiction": The principal investigator is Albert Kurland, M.D., director of research, Maryland State Department of Mental Hygiene, Baltimore, Md., and the grant is to that agency.

6. MH-01012. "Narcotics": The principal investigator is Thomas H. Sternberg, M.D., professor of medicine, University of California, Los Angeles, Calif. The grant to that agency supported a 2-day symposium on narcotics.

7. MH-01157, "NYU-Greenwich House Community-Based Addiction Program": The principal investigator is Robert Osnos, M.D., project director, Greenwich House Counseling Center, New York, N.Y., and the grant is to New York University.

8. and 9. MH-01292. "Halfway House and Testing Program for Drug Addicts": The principal investigator is Joseph A. Shelly, M.A., chief probation officer, Supreme Court of the State of New York, Brooklyn, N.Y., and the grant is to that agency. It was preceded by MH-00955, "Drug Addicts Treated by Nalline, Group Therapy, Probation Supervision."

10. MH-01393. "A Day-Night Center for Addicted Persons": The principal investigator is Richard Brotman, Ph. D., associate professor, Department of Psychiatry, New York Medical College, New York, N.Y., and the grant is to that agency.

11. MH-01982. "Development of Narcotics Addiction Therapy Programs": The principal investigator is Reuben S. Horlick, Ph. D., chief, psychological services, District of Columbia Department of Corrections, Washington, D.C., and the grant is to that agency.

There are no legal problems which prevent full utilization of section 303 to support research and demonstrations in the field of narcotic addiction.

The NIMH estimates that it will support 11 projects totaling $500,000 in the field of drug addiction in fiscal year 1966, under section 303; in 1962 it supported 6 projects totaling $491,000. Support under this section has been increasing. Total support under all programs of the NIMH in 1966 is estimated to be $3,293,000. There has been no lack of funds to support such projects. Because not all projects are judged to be scientifically sound by the National Advisory Mental Health Council, some are not supported.

The National Institute of Mental Health has recently established a section on alcoholism and drug abuse. Among its functions are the stimulation of applications in this field and consultation when necessary to aid in preparation of the applications. In addition, the mental health consultants in the regional offices also aid potential applicants and disseminate information concerning the nature of projects supportable under section 303.

Mr. JAVITS. Mr. President, the record of research activity, however, is clearly inadequate to the gaps in our knowledge of this subject. One of the problems

is training sufficient personnel to conduct research projects and demonstrations. A provision of one of the bills being introduced today is designed to assist in the training of such personnel. There is also a lack of widespread knowledge even among professional researchers, that such research assistance is currently available from the Federal Government under section 303. Another provision of our bills is intended to direct the Department of Health, Education, and Welfare to encourage the use of section 303 as well as other presently existing sources of research assistance under the Public Health Service Act.

Many experts believe that a serious deficiency in the Federal approach has inhibited research into cures for narcotics addiction. These critics have said that physicians and medical researchers are deterred from participating in narcotics research because they fear that the Bureau of Narcotics, acting under its regulations, will proceed against them for criminal violation of the Federal narcotics laws. The Senate Permanent Investigations Subcommittee in its report early this year very commendably recommended that the Bureau of Narcotics give further close study to the language used in section 151.392 of regulation No. 5, its regulation concerning physicians. Such a reevaluation, made together with representatives of the medical profession, would go a long way toward eliminating misunderstandings of the Bureau's policy.

I ask unanimous consent that there be printed in the Record at this point in my remarks the exchange of correspondence which Senator Kennedy and I have had with the Director of the Bureau of Narcotics on this subject.

There being no objection, the exchange of correspondence was ordered to be printed in the Record, as follows:

APRIL 24, 1965.

HON. HENRY L. GIORDANO,
Commissioner of Narcotics, Bureau of Narcotics,
Department of the Treasury,
Washington, D.C.

DEAR MR. COMMISSIONER: As you know, in the course of our long interest in and concern about narcotics addiction, we have taken the view that the Bureau of Narcotics should reevaluate the language used in section 151.392 of regulation No. 5, your regulation concerning physicians.

Testimony given last year before the Investigations Subcommittee of the Senate Government Operations Committee revealed the consternation which exists in the medical profession about that regulation language and raised the question as to whether the language inhibits the development of more effective medical techniques of combating addiction.

As a result of a recent inquiry which was made of the Bureau, at our request, as to the possibility of arranging a meeting on this subject with representatives of the medical profession, it is our understanding that the Bureau has now determined to undertake a revision of the regulation language in question and proposes thereafter to take into consideration the views of the Justice Department, the national medical associations, and the various New York groups which have been active in this field. We would very much appreciate having your confirmation of our understanding, particularly with reference to the following points:

1. Precisely what provisions in section 151.392 does the Bureau now propose to revise?

2. With what objective is the Bureau undertaking revision of these provisions?

3. At what point in the process of developing new provisions will the various medical groups be given an opportunity to participate? Will this opportunity be afforded before the revised regulations become a matter of public record or are otherwise formalized?

4. Would it be possible at this point to select a date for a meeting at which the Bureau could explain to the medical groups how it proposes to proceed with the revision and to receive suggestions from the interested groups?

We would very much appreciate your earliest attention to this matter, which, as you know, is of increasingly great concern to the entire community in New York City.

With best wishes.

Sincerely.

JACOB K. JAVITS,
U. S. Senator.
ROBERT F. KENNEDY,
U. S. Senator.

TREASURY DEPARTMENT,
BUREAU OF NARCOTICS,
Washington, D.C., May 10, 1965.

DEAR SENATORS JAVITS and KENNEDY: This will acknowledge receipt of your letter of April 24, 1965, which concerned the language used in section 151.392, title 26, Code of Federal Regulations.

Upon receipt of Report No. 72 of the Senate Permanent Subcommittee on Investigations, I noted the recommendation on page 127 that the Bureau of Narcotics give further close study to the language used in section 151.392 to determine whether it could be revised for purposes of clear interpretation. Accordingly, this matter is currently under study, although final determination has not been made.

I can assure you, however, that we are giving this matter full attention and at the appropriate time, we will be in contact with other interested agencies and organizations.

Before any proposed changes in the regulation could take effect, a notice would first have to be published in the Federal Register. Thirty days would then have to elapse before the regulation would become final upon second publication.

Sincerely yours,

HENRY L. GIORDANO,
Commissioner of Narcotics.

TREASURY DEPARTMENT,
BUREAU OF NARCOTICS,
Washington, D.C., June 2, 1965.

DEAR SENATORS JAVITS and KENNEDY: In response to your further inquiry relative to the joint letter I received from you, I wish to make the following observations on the four questions raised therein:

(1) The part of section 151.392 which appears to be at issue is as follows: "An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of section 4705(c)(2)."

(2) The Bnreau is carefully studying section 151.392 to see what changes in language or additional phraseology may be necessary to clarify any misunderstanding that this section was intended to restrict bona fide medical treatment. Initially, section 151.392 was carefully phrased to insure compliance with the provision of 26 U.S.C. 4705(c)(2) which requires that narcotic drugs be dispensed or distributed by a practitioner "* * * in the coure of his professional practice only * * *." Both 4705(c)(2) and 151.392 are intended to discourage those few practitioners who are inclined to do so, from abusing their narcotic privileges by dispensing narcotic drugs for other than for bona fide medical need. In considering any revision of 151.392 our purpose is to insure compliance with 4705(c)(2), and at the same time to make it clear that prescriptions may be issued for the treatment of a habitual user of narcotics in accordance with accepted medical practice.

(3) If section 151.392 is revised, it would be submitted to Treasury and Justice Department officials for review and comment. Subsequently, any revision would be discussed with the American Medical Association, the National Research Council, and other interested medical groups.

(4) In view of the careful and extensive review which is intended to be afforded any revision of section 151.392, it would not be possible at this time to select a date when this matter would be resolved.

Sincerely yours,

HENRY L. GIORDANO,
Commissioner of Narcotics.

Mr. JAVITS. Mr. President, finally, a word should be said about one feature of the narcotics picture which has perhaps caused more trouble and more excuse for delay in this field than any other. Nothing tends to divert attention from the principles outlined above and incorporated in the bills now being introduced than reference to the so-called British system of allegedly maintaining addicts on free narcotics supplied by the Government. The controversy immediately boils up over what the British system really is, whether addicts can, in fact, be maintained on stable dosages, whether chemical substitutes such as methadone can be

utilized, or whether conditions exist in the United States which would make any such system workable.

I do not believe controversy over these issues should becloud the pressing urgency for action on the series of proposals which are here being introduced. Personally, I favor a limited research effort toward determining what the answers are to the arguments for maintenance of the addicts on drugs from medical treatment sources, and a few such experiments are presently underway; notably by the State of New York Department of Mental Hygiene. But it should be clear that the bills now introduced do not call for or advocate adoption of such a system and the debate over that system and its testing should accelerate not frustrate prompt action by the Congress on these measures, so critical is the problem now.

I yield now to my colleague from New York, Mr. Kennedy.

Mr. KENNEDY of New York. Mr. President, I introduce for appropriate reference on behalf of myself, Senator Javits, Senator Ervin, Senator Hart, Senator Williams of New Jersey, Senator Tydings, Senator Kuchel, and Senator Case, two bills concerning the problems of narcotics and drug abuse—a bill providing certain reforms in the Federal criminal law as it relates to narcotics, and providing a postconviction sentencing program by which convicted persons may be sentenced to a treatment program instead of to prison, and a bill to assist States, political subdivisions, and private nonprofit orgaulzations in providing treatment and rehabilitation services for drug abusers. Senator Saltonstall is also a cosponsor of the former bill, and Senator Long of Missouri is a cosponsor of the latter bill.

Preceding my introduction of these bills, Senator Javits has introduced two other bills; one which provides for pretrial civil commitment for Federal narcotics violators, and the other providing aid to the States for construction and acquisition of treatment facilities.

The package of four bills will, in my judgment, go a long way to updating the Federal approach to narcotics problems and, perhaps even more important, to stimulating more extensive State, local, and private efforts to help narcotic addicts and other drug abusers.

We have somewhere between 50,000 and 100,000 narcotic addicts in this country. Their affliction affects not only their own lives, but the lives of their families as well. As a result of the crimes they commit to get money to support their addiction, they cost society hundreds of millions of dollars annually. We need to do much more to get at the roots of this problem than we have done up to now, and that is why we introduce this legislation today.

These bills are the product of months of effort and study. Many of their provisions are based upon the findings and recommendations of the President's Advisory Commission on Narcotic aud Drug Abuse in 1963. In addition, in preparing the bills, we have consulted extensively with knowledgeable officials at the Department of Justice, the Department of Health, Education, and Welfare, the National Institute of Mental Health, and the Bureau of Narcotics.

I cannot say that each and every provision of each bill has the full agreement of every relevant official in these executive departments, but I can say that I think these bills represent a resolution of the sometimes conflicting views that can be found among the experts in the field. With the extensive support which we have among our colleagues in the Senate, and the wide interest on the House side, in introducing the bills, these bills have the best chance of passage of any narcotics reform legislation to be offered in recent years.

I have listed our cosponsors in the Senate, and in the House. Some or all of the bills will be offered by Congressmen Celler, Harris, Mills, Delaney, Farbstein, Ryan, and Ottinger, among the Democrats, and Congressmen McCulloch, Springer, Reid, Lindsay, Bell, and Mathias among the Republicans. I am particularly grateful for the support of the Senator from North Carolina, Mr. Ervin. His long interest in law reform and in the narcotics field and his wide knowledge of these matters make his support particularly helpful.

President Johnson in his message on crime earlier this year called for legislation to establish civil commitment and to make the Federal narcotics law more flexible. I look forward to supporting these bills when they come up and to working for their passage in conjunction with the program we are offering today.

Let me turn to discussion of the bills we introduce today. One of the most important efforts which the Federal Government can make to help in connection with narcotics and drug abuse problems is to stimulate increased efforts by States, cities, and private individuals and organizations to treat and rehabilitate addicts and to engage in research into the problems of drug abuse.

That is the basic purpose of the services bill which I am introducing. It authorizes $7,500,000 a year for grants for treatment and rehabilitative services, not only for narcotic addicts, but for users of depressant and stimulant drugs—like the barbiturates and the amphetamines—as well. New York, California, and other States have made a start in this area, at least so far as narcotic addicts are concerned, but more—much more—is needed.

One basic reason why more has not been done is that scientists and psychiatrists and medical experts have been reluctant to enter upon research and treatment efforts regarding addicts. This is understandable, because 75 percent of the addict population comes from the 20 percent of society whose incomes are the lowest. It is hard to convince an addict that there really is hope, that he should seriously commit himself to a program which seeks to make him a member of a society that never before did anything good for him. The difficulty of dealing with addicts has, unfortunately, discouraged too many competent scientists and researchers from involving themselves in the addiction problem. It is an essential purpose of this bill to reverse that pattern of reluctance.

The aid which the bill provides is for treatment and rehabilitation services of all types—including medical treatment, family counseling, psychotherapy, vocational training, help in finding employment, and probation-type supervision. Most of the aid would go to the States, cities, and private, nonprofit organizations under a State plan and would be on a two-thirds to one-third matching basis, but up to 20 percent could be given directly to nonprofit organizations. These groups often find it hard to obtain other financing, and therefore are in need of 100-percent grants.

Underscoring the emphasis on bringing new programs into existence, the bill specifically provides that aid is to be available for the training of personnel in all relevant fields, and for the undertaking by the States of specific statistical studies to determine the full extent of the drug abuse problem and to follow particular groups of young people to see why some become addicts and others do not.

The purpose of the bill to encourage new efforts and the entry of new personnel into the narcotics and research fields is reflected also in the duties given the advisory committee which is created by the bill. That committee is charged with advising the Surgeon General in his administration of the research grants now available under section 303 of the Public Health Service Act, for the purpose of encouraging new research efforts, particularly on a long-term contract and collaborative study basis.

This purpose is borne out in title II of the services bill as well. This title broadens the mission of the Public Health Service hospitals in Lexington, Ky., and Fort Worth, Tex., to include research, training, and demonstration in the care and treatment of drug abusers. Equally important, the mission of these hospitals is, considered with the overall purpose of the bill, broadened to include the problems of all types of drug abusers, including those who use barbiturates, amphetamines, and other stimulant and depressant drugs. We know all too little about the problems associated with these dangerous drugs, but we do know there are increasingly serious problems stemming from their widening use. Research and treatment in the dangerous drug area at Lexington and Fort Worth would be most helpful.

These aspects of the bill complement the regulatory provisions of H.R. 2, which has been passed by the House and was reported yesterday by the Senate Labor and Public Welfare Committee. That bill provides badly needed regulation of the traffic in dangerous drugs; my services bill, together with Senator Javits' construction bill will, among other things, provide treatment facilities for those who have been the victims of the traffic.

We cannot ever lose sight of the fact that many of the problems underlying addiction are the same ones that underlie much of the problem of crime in the streets and delinquency. We will never erase addiction until we erase poverty and discrimination—until we can give the addict adequate educational and employment opportunities as an alternative way to turn.

Nevertheless, since the addict's personal problems are psychological and should be susceptible of treatment as is any mental illness, there is much that can be accomplished through better and more extensive treatment programs and better and more extensive research. Monetarily, the bill is oriented primarily toward the former category, since research money is available under section 303 of the Public Health Service Act, but in overall purpose, the bill's point is to encourage greater efforts in both the research and treatment areas.

I hope that the aid provided by this bill will be used for all types of treatment programs, since we do not yet have any one sure-fire way to bring addicts permanently into organized society. In general, I think it is safe to say that it would be extremely useful to devote a substantial portion of the aid which the bill offers to the critical period of aftercare—making sure that the former addict has close attention, over an extended period of time, both psychiatric and vocational, to make sure that he always has someone and something that can offer tangible reason for not slipping back.

Beyond this, however, there are many questions. Should the addict be removed from his original environment and placed in drug-free surroundings for a long period of time while he is getting psychiatric help and vocational training? Or should an attempt be made to place him in some kind of halfway house or other facility in his home environment once he is no longer physically addicted, where he will live and participate while he gradually attains membership in organized society? Or is the addict such an inherently weak personality that he can never successfully return to his original environment, so that the only possible program is one which removes him permanently from his original surroundings and gradually makes him a part of an entirely new and permanent social arrangement, of what might be called a reservation village? To what extent should all of this involve only the addict, and to what extent should the rest of his family be brought into it as well?

All of these approaches deserve a full look. To some extent such a look can be provided by the research grants available under section 303 of the Public Health Service Act, but if we are to have a comprehensive set of treatment programs on a continuing basis, the services bill which I am introducing today is an absolute must. The research moneys under section 303 are by definition not available for continuing projects. I think it is imperative that we act now to create the kind of Federal encouragement to the States and others which this bill contemplates.

Turning to the other bill of which I am the principal sponsor, its design is twofold:

First. To enhance prosecutorial discretion in the enforcement of the Federal narcotics laws, and

Second. To provide incentive for addicts convicted of Federal crimes to involve themselves successfully in a treatment program in the prison system.

The person who violates the Federal narcotics laws is ordinarily guilty of two violations: violation of the Narcotic Drug Import and Export Act, the provisions of which are in title 21 of the United States Code, and violation of the regulatory tax provisions of the Internal Revenue Code. At present there are mandatory minimum sentences for violation of both of these sets of provisions, with some minor exceptions.

What the bill would do would be to eliminate most of the mandatory minimum sentences in the Internal Revenue Code, while retaining the mandatory minimum provisions in the Narcotic Drugs Import and Export Act. Since the latter is the more stringent act, this reform would give prosecutors a discretion to decide whether an accused is a major peddler of narcotics and should be tried under the stringent provisions of the Narcotic Drugs Import and Export Act, or is an addict who has been arrested for what amounts to be a possessory offense and deserves more lenient treatment. The overall point of this reform, and of the other reforms which the bill accomplishes, is to give the addict-violator some incentive to rehabilitate himself successfully while he is in custody. As long as he faces a long mandatory minimum sentence, that incentive is practically destroyed.

Along these same lines, the bill extends the flexible sentencing provisions of the Federal Youth Corrections Act to all violators up to the age of 26, regardless of whether a mandatory sentence is involved for the violation. In addition, the bill extends the possibility of parole, on a limited basis, to those convicted of offenses for which there is a mandatory minimum. It makes them eligible for parole once they have completed their minimum sentence, assuming they are otherwise eligible at that time. These changes all provide a useful and important flexibility without jeopardizing the effectiveness of the strong penalties of the Narcotic Drugs Import and Export Act.

Part of the needed flexibility has been accomplished by an administrative directive, put out while I was Attorney General, that required first offenders to be tried under the more lenient provisions of the Internal Revenue Code, but far more flexibility is needed if the requisite level of reform and incentive for rehabilitation is to be attained. That additional flexibility can be obtained only by amending the law.

For all the offenses as to which the bill eliminates the mandatory minimum sentence, that elimination carries with it elimination of the ban on parole, suspension of sentence, and probation. The incentive which these reforms will create for rehabilitative efforts must be given concrete application through the creation of an addict treatment program. To that end, the bill provides that the sentencing judge or the Attorney General may send a narcotic addict convicted of any Federal crime, or really anyone who has the same kind of underlying mental or physical problem, which would include the user of dangerous drugs, to a postconviction treatment program in an appropriate Federal facility or in a State or local facility operated on contract with the Bureau of Prisons. The bill also provides that anyone released on parole following such a treatment program can be released into a special aftercare program instead of the usual parole-type supervision.

Hopefully, the provisions of this bill will result in far greater flexibility in the administration of the Federal criminal law and in far more effective treatment and rehabilitation of addicts who are convicted of a Federal crime. We all agree that we must continue to spare no effort in trying to stop the illegal traffic in narcotics and to apprehend those involved. I was certainly deeply involved in that effort while I was Attorney General. Nevertheless, better protection and incentive for the addict-violator is needed, and I think the bill which I introduce today can provide that without in the least jeopardizing the law enforcement effort against major traffickers in narcotics.

Mr. JAVITS. Mr. President, I ask unanimous consent that a summary of our bills, a section-by-section analysis of our bills, and the text of the bills may be made a part of our remarks, and that the bills lie on the desk for additional cosponsors for 1 week.

There being no objection, the material was ordered to be printed in the Record, as follows:

[Summary of bills]

SUMMARY OF LEGISLATION ON NARCOTICS AND DRUG ABUSE

I

The civil commitment bill is similar to the New York State law in this area, and to proposals which have been advanced at the Federal level for some time. It provides that certain persons accused of a violation of the Federal narcotics laws can be given the option of undertaking a mandatory civil commitment program of medical treatment and rehabilitation instead of standing trial. This program would not be available to persons charged with selling narcotics for resale, to persons convicted of two or more felonies, to persons against whom a prior felony charge is already pending, and to persons previously participating in civil commitment programs at the State or Federal level on two or more occasions.

The period of civil commitment would be up to 36 months, followed by a period of probationary aftercare for up to 2 years. The bill provides for resumption of criminal prosecution against those who refuse to cooperate or are otherwise nonresponsive to the program.

II

The bill relating to reform of the existing criminal law is designed to enhance prosecutorial discretion in enforcing the narcotics laws and to provide incentive for narcotic addicts convicted of Federal crime, not necessarily only narcotics violations, to involve themselves successfully in a treatment program in the prison system.

The bill eliminates mandatory minimum sentences for marihuana violators and for violators of the regulatory tax provisions of the Internal Revenue Code. The bill would retain the stringent provisions which now exist in the Narcotic Drugs Import and Export Act and are necessary to deal with major peddlers of narcotics.

In addition, the bill makes the parole provisions of title 18 and the Federal Youth Corrections Act applicable to those offenses for which mandatory minimum sentences are retained. These changes provide a useful flexibility without jeopardizing the hard core of stringent penalties available under the Narcotic Drugs Import and Export Act for persons as to whom these penalties are appropriate.

Finally, the bill provides that either the Attorney General or the sentencing judge may send any narcotic addict or any person with a similar underlying mental or physical condition (which would include those who use dangerous drugs) into a treatment program instead of into the usual prison atmosphere. The bill further provides for extensive aftercare treatment for such persons when they are paroled, in lieu of the usual, less intensive parole supervision. These provisions, together with the parole reforms mentioned above, will provide a realistic incentive for the narcotic addict or dangerous drug abuser to make a genuine attempt to rehabilitate himself and obtain the vocational training necessary to help him become a useful member of organized society.

III

The services bill provides $7,500,000 a year for 3 years to aid in the establishment, development, and maintenance of treatment and rehabilitation services for drug abusers. The services include the full range of medical and psychiatric services, vocational training of personnel in the various relevant fields, and for the undertaking by the States of statistical studies to determine the full extent of the drug abuse problem.

The bill contemplates that at least 80 percent of the grants will go to the States on a two-thirds—one-third matching basis, pursuant to State plans filed with the Secretary of Health, Education, and Welfare. The States will use the funds themselves and also distribute them to the political subdivisions and to private nonprofit organizations in accordance with their plan. Up to 20 percent of the funds can be given by way of direct 100-percent grants to private nonprofit organizations after consultation with the State.

The bill specifically provides that the State plan is to be filed along with and as a separate part of the mental health plan which the State files under title III of the Public Health Services Act.

Thus, the bill is keyed directly into the existing procedures under the Public Health Services Act, and is directly related to existing Federal programs on mental health.

A major aim of the bill, which is reflected both in the type of aid which can be given and in the duties with which the advisory committee created by the bill is charged, is to encourage new people to enter the narcotics treatment field. Perhaps the most significant problem in the narcotics area today is the lack of sufficient professional people engaged in treatment. One of the most important reasons for having a program such as the one contemplated by the bill is to put the full force of the Federal Government behind the process of encouraging new people to enter this field.

The bill also has a title II, the purpose of which is to broaden the definition of narcotics and narcotic drugs in the Public Health Service Act, so that the efforts of the Public Health Service in this area will extend to the barbiturates, amphetamines, and other dangerous drugs, instead of merely to the opiates and other narcotics. Specifically, these amendments would result in broadening the mission of the Public Health Service hospitals at Lexington, Ky., and Fort Worth, Tex., to include research into and treatment of the problems of dangerous drug users.

IV

The bill to provide aid for construction and acquisition of treatment facilities is structured in much the same way as the bill to provide aid for services, except that the aid is to be distributed entirely in accordance with the State plan. The bill provides an authorization of $15 million a year for 3 years.

The bill is, again, designed as a supplement to the mental health aid which the States have already received. Grants under the bill are limited to two-thirds of the project cost.

The facilities contemplated by the bill include the entire possible range of treatment facilities for narcotic addicts and other drug abusers. Thus, the facility might be halfway house, or a camp, or a sheltered workshop. The facility might be one which offers vocational training and help in finding employment, as well as psychiatric aid and counseling.

A major aim of the bill is to aid the States and their subdivisions in providing needed facilities for the crucial period of aftercare and adjustment of those who have been taken off narcotics.

[Section-by-section analysis of bill]

SECTION-BY-SECTION ANALYSIS OF LEGISLATION ON NARCOTICS AND DRUG ABUSE

I

A bill to authorize civil commitment in lieu of criminal imprisonment in certain cases involving narcotics addicts (Senator Javits).

Secton 1: Defines "narcotic drug" and "narcotic addict."

Section 2(a): Provides that any person charged with violation of Federal narcotics law is to be informed by the committing magistrate of an option to elect civil commitment in lieu of prosecution. The accused is given 10 days within which to make his election.

Section 2(b): Provides that any person who elects to be considered for civil commitment is to be turned over to the Surgeon General for examination to determine if he is an addict.

Section 2(c): Provides the list of persons who may not be given the option of civil commitment:

1. If the violation involved the sale of narcotics for resale;
2. If the person has another charge pending against him or has not fully served the sentence, including time on parole, for another crime;
3. If the person has been convicted of two or more felonies;
4. If the person has been involved in civil commitment by the United States or any State on two or more prior occasions.

Section 3(a): Provides that the examination is to be made by the Surgeon General within 10 days, and that the accused is to have a hearing if he wishes to contest the findings.

Section 3(b): Directs the court to receive all relevant evidence.

Section 3(c): Directs that if the court finds that the person is not a narcotic addict, he shall be tried for the criminal charges, and if the court finds that he is a narcotic addict, he is to be committed to the custody of the Surgeon General for proper treatment.

Section 3(d): Provides that criminal charges for those civilly committed are to be continued without final disposition while the commitment process is going on.

Section 4(a): Provides that commitment is to be for an indeterminate period up to 36 months. The person committed is to be returned to the court if:

1. He is unresponsive to treatment,
2. He is effectively removed from the habitual use of narcotic drugs, or
3. Thirty-six months have passed.

Section 4(b): Provides that those returned to the court under paragraphs 2 or 3 of section 4(a) may be placed in an aftercare program for up to 2 years.

Section 4(c): Provides that those returned under paragraph 1 in section 4(a) may be prosecuted under the original criminal charges.

Section 5(a): Provides that those who fail to cooperate during the aftercare period may be tried on the original criminal charges. Section 5(a) specifically requires that resumption of use of narcotics is not to be the basis of prosecution on the original charges unless the Surgeon General has given the person a warning and a chance to stop once he finds the person to be using the drugs.

Section 5(b): Directs the Surgeon General to tell the court when a person has successfully completed the aftercare program, and directs the court at that time to dismiss the criminal charges.

Section 6: Provides that a person tried on a resumed basis will receive credit for all time spent in custody under this act.

Section 7: Provides that a determination by the court that a person is a narcotic addict shall not be considered a criminal conviction.

Section 8: Authorizes the Surgeon General to contract with States and subdivisions for use of appropriate facilities.

Section 9: Provides that "State" includes the District of Columbia.

Section 10: Limits the act to arrests made after December 31, 1965.

II

A bill relating to the penalties for violations of certain narcotic and marihuana laws of the United States, and to the treatment of narcotic addicts and other persons suffering from a mental or physical condition committed to the custody of the Attorney General (Senator Kennedy of New York).

Section 1: Eliminates the mandatory minimum sentence for marihuana violators now provided in 21 U.S.C. 176. Eliminates the prohibition on probation, suspension of sentence, and parole for marihuana violators.

Section 2(a): Eliminates the mandatory minimum penalties for certain aspects of the narcotics law which are contained in the regulatory tax provisions of the Internal Revenue Code. (26 U.S.C. sections 4704, 4705, etc.)

Section 2(b): Eliminates the mandatory minimum sentence for the offense of sale of narcotics in violation of the Internal Revenue Code (26 U.S.C. section 7237(b)), as opposed to the mandatory minimums for sale of narcotics in violation of the Narcotic Drugs Import and Export Act (21 U.S.C. section 171 et seq.), which are retained. Section 2(b) further provides that a 5-year mandatory minimum for the offense of selling or conspiring to sell narcotics to persons under 18 in violation of the Internal Revenue Code is retained.

Section 3: Amends 7237(d) of the Internal Revenue Code to allow parole for all narcotics violations and to allow suspension of sentence and probation for those offenses as to which the mandatory minimums are eliminated in sections 1 and 2. Parole is made available to offenders who receive mandatory minimum sentences only after they serve the mandatory minimum. The prohibition on suspension of sentence and probation is retained for those offenses as to which the mandatory minimum is retained.

Section 4: Adds a new section 5027 to title 18, thereby extending the Federal Youth Corrections Act to narcotics violations involving mandatory penalties.

Section 5: Extends the extension of the Federal Youth Corrections Act contained in 18 U.S.C. section 4209 to narcotic offenses involving a mandatory minimum penalty.

Sections 6, 7, and 8 taken together provide for a postconviction sentencing procedure whereby narcotic addicts and others with similar underlying mental and physical symptoms, upon conviction of any Federal crime, can be placed in a program of treatment and rehabilitation separate and apart from the ordinary prison environment.

Section 6: Adds a new section 4002A to title 18. This gives the Director of the Bureau of Prisons authority, in addition to other authority available to him, to contract with States and political subdivisions for the use of facilities for care, treatment, and rehabilitation (including vocational rehabilitation of appropriate persons being held in his custody.

Section 7: Adds a new section 4082A to title 18. This gives the Attorney General power to place any narcotic addict or any other person suffering from a mental or physical condition which might be helped by proper care, treatment, or rehabilitation (including vocational rehabilitation), in a facility appropriate for that purpose. Section 7 also adds a new section 4082B to title 18, which gives to the sentencing judge the same power as the proposed 4082A gives to the Attorney General.

Section 8: Adds a new section 4203A to title 18 to provide that when persons who have been confined pursuant to the proposed sections 4082A and 4082B are released on parole they may be released into special aftercare programs. The new section 4203A also authorized the Board of Parole to utilize the services of any State or any other organization in providing such aftercare, and authorized the Board of Parole to contract for such services. The "supervision" of a State or local agency, organization, or group under the new section 4203A is not intended to derogate from the overall control by the Attorney General of the parolee, as provided in 18 U.S.C. 4203.

III

A bill to provide financial assistance to the States to assist them in establishing treatment and rehabilitation services for drug abusers (Senator Kennedy of New York).

Section 101: Short title, Drug Abusers Treatment Services Act.

Section 102(a): Authorizes $7,500,000 annually for 3 fiscal years to aid the States in providing treatment and rehabilitation services for drug abusers.

Section 102(b): Provides that at least 80 percent of the funds each year will be distributed to the States in accordance with a State plan as provided in section 104. The grants to the States are to include grants for the training of personnel who will administer treatment services and grants for the obtaining of accurate statistics regarding the extent of the drug abuse problem. Up to 20 percent of the funds can be distributed directly to private nonprofit organizations which offer treatment services.

Section 102(c): Sums appropriated under section 102(a) are to remain available until expended, except that applications must be filed before July 1, 1968, and approved before July 1, 1969.

Section 103(a): Directs the Secretary of HEW to issue regulations. Specifically directs that the regulations are to include provisions for the kind of services for which grants can be made—including, but not limited to, detoxification or other medical treatment, physical therapy, family counseling, psychotherapy, vocational training, help in finding employment, and probation-type supervision.

Section 103(b): Provides that the regulations may require that applicants for grants promise to make a reasonable amount of their services available to people unable to pay.

Section 104(a): Provides for the State plan. Requires that the State plan, among other things:

1. Set forth its program, and
2. Designate a single State agency to supervise the plan.

Section 104(b): Provides that the State plan is to be submitted as a separate and distinct part of the State mental health plan which it submits to the Public Health Service annually under title III of the Public Health Service Act.

Section 104(c); Provides that the Secretary may approve any State plan which conforms substantially with section 104(a), and may not disapprove any plan without reasonable notice and opportunity for a hearing.

Secion 105(a): Provides for the form and content of specific applications for grants pursuant to approved State plans, and allows joint applications by States, subdivisions, and nonprofit organizations working on joint projects.

Section 105(b): Provides that the Secretary may approve any specific application filed under section 105(a) if it conforms to the regulations and State plan.

Section 106(a): Provides for the form and content of applications for grants by nonprofit organization apart from the State plan, as provided for in section 102(b), which allows up to 20 percent of the funds to be gained directly to nonprofit organizations.

Section 106(b): Provides that the Secretary may approve an application under section 106(a) if he finds that it conforms to the law and regulations, and that, after consultation with the agency, the application is not inconsistent with the State plan.

Section 106(c): Provides that the Secretary may require reports by grant recipients.

Section 107: Allows grants to be in advance or by way of reimbursement and in such installments and on such conditions as the Secretary finds necessary. Grants under the State plan are limited to two-thirds of the project cost. Grants directly to private organizations may cover 100 percent of the project cost.

Section 108(a): Creates a nine-member advisory committee on drug abuse, and provides for the time sequence of appointments. Provides, also, that members of the advisory committee are to be drawn from all fields concerned with drug abuse.

Section 108(b): Sets out the duties of the advisory committee to advise the Secretary and to assist the States in the preparation of their State plans and to assist in encouraging the development of research projects and treatment programs at the local level.

Section 108(c): Provides $75 per diem compensation for members of the advisory committee.

Section 108(d): Directs the committee to elect a chairman and directs the Secretary to provide needed technical and clerical assistance to the committee.

Section 109(a): Provides for cutoff of funds by the Secretary when he finds that a State agency is not carrying out its plan.

Section 109(b): Provides for cutoff of funds by the Secretary when he finds that a nonprofit organization is not living up to the terms of the grant.

Section 110(a): Describes the technical assistance which the Secretary may render under the act, including the training of personnel and the making of studies relating to treatment and rehabilitation of drug abusers.

Section 110(b): Authorizes the Secretary to gather and disseminate information and materials relating to the treatment and rehabilitation of drug abusers.

Section 111: Provides judicial review in the courts of appeals for dissatisfied States and nonprofit organizations.

Section 112: Defines terms. Drug abuser is defined broadly, to insure inclusion of those who use barbiturates, amphetamines, and other dangerous drugs, as well as the opiates.

Sections 201, 202, and 203 amend the Public Health Service Act to extend its application to the so-called dangerous drugs as well as the opiates and other

drugs previously included. The major effect of this is to broaden the mission of the Public Health Service hospitals at Lexington, Ky., and Fort Worth, Tex., to allow them to treat all types of drug abusers instead of just those who use narcotics as previously defined. Section 201 also specifically broadens the mission of the Lexington and Fort Worth hospitals to include research, training, and demonstration in the care and treatment of all types of drug abusers. Section 201 is intended to encourage the Surgeon General to select for research and demonstration programs those patients who are most suitable therefor, and who are most amenable to the particular program involved.

A bill to provide financial assistance to the States to assist them in the construction of facilities for the treatment of rehabilitation of drug abusers (Senator Javits).

Section 1: Short title of the act—Drug Abusers Treatment Facilities Act.

Section 2(a): Authorizes appropriation of $15 million a year for 3 years.

Section 2(b): Provides that such funds are to be available to assist the States in constructing facilities for the treatment and rehabilitation of drug abusers and to provide relevant technical assistance to the States.

Section 2(c): Sums appropriated under section 2(a) are to remain available until expended, except that applications must be filed before July 1, 1968, and approved before July 1, 1969.

Section 3(a): Provides that the regulations may require that applicants for grants promise to make a reasonable amount of their services available to people unable to pay.

Section 3(b): Provides that the regulations may require that applicants for grants promise to make a reasonable amount of their services available to people unable to pay.

Section 4(a): Provides for the State plan. Requires that the State plan, among other things:

1. Set forth its program, and
2. Designate a single State agency to supervise the plan.

Section 4(b): Provides that the State plan is to be submitted as a separate and distinct part of the State mental health plan which it submits to the Public Health Service annually under title III of the Public Health Service Act.

Section 4(c): Provides that the Secretary may approve any State plan which conforms substantially with section 4(a), and may not disapprove any plan without reasonable notice and opportunity for a hearing.

Section 5(a): Provides for the form and content of specific applications for grants pursuant to approved State plans, and allows joint applications by States, subdivisions and nonprofit organizations working on joint projects. Requires that the application shall describe the site, the project plan, and shall contain various assurances.

Section 5(b): Provides that the Secretary may approve any specific application filed under section 105(a) if it conforms to the regulations and State plan.

Section 6: Allows grants to be in advance or by way of reimbursement and in such installments and on such conditions as the Secretary finds necessary. Provides further that amounts paid are limited to two-thirds of the construction cost.

Section 7: Provides for cutoff of funds by the Secretary when he finds that a State agency is not living up to the terms of the grant.

Section 8: Provides for appropriate recovery by the United States if, within 20 years, the facility is sold to any nonprofit organization or ceases to be used for the purpose for which it was constructed.

Section 9: Provides judicial review in the courts of appeals for dissatisfied States.

Section 10: Authorizes the Secretary to appoint committees as he deems it necessary.

Section 11: Defines terms, drug abuser is defined broadly, to insure inclusion of those who use barbiturates, amphetamines, and other dangerous drugs, as well as the opiates. "Facilities" are defined as "buildings or other facilities which are operated for the primary purpose of assisting in the treatment and rehabilitation of drug abusers by providing, under competent professional supervision, detoxification or other medical treatment, physical therapy, family counseling, psychotherapy, vocational services, help in finding employment, or other services." "Facilities" include facilities for medical care, laboratories, community clinics, halfway houses, sheltered workshops. "Construction" includes not only any new building but also acquisition, expansion, remodeling, and alteration of existing buildings, and payment of architect's fees. "Construction"

specifically does not include the cost of off-site improvements and acquisitions of land.

The PRESIDING OFFICER. The bills will be received and appropriately referred; and, without objection, the bills will be printed in the Record, and held at the desk for additional cosponsors, as requested.

The bills were received, read twice by their titles, appropriately referred, and ordered to be printed in the Record, as follows:

[Text of bills]

S. 2113. A bill to authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts; to the Committee on the Judiciary, introduced by Mr. JAVITS (for himself, Mr. KENNEDY of New York, Mr. CASE, Mr. ERVIN, Mr. HART, Mr. KUCHEL, Mr. SALTONSTALL, Mr. SCOTT, Mr. TYDINGS, and Mr. WILLIAMS of New Jersey).

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed therennder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(1) the violation involved the sale of narcotics by such person so charged to another, with knowledge that the person to whom the sale was made intended to dispose of such narcotics by resale;

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be

made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraphs (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

S. 2114. A bill relating to the penalties for violations of certain narcotic and marihuana laws of the United States, and to the treatment of narcotic addicts and other persons suffering from a mental or physical condition committed to the custody of the Attorney General; to the Committee on the Judiciary, introduced by Mr. Kennedy of New York (for himself, Mr. Javits, Mr. Case, Mr. Ervin, Mr. Hart, Mr. Kuchel, Mr. Saltonstall, Mr. Tydings, and Mr. Williams of New Jersey).

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 2(h) of the Narcotic Drugs Import and Export Act, as amended (21 U.S.C. 176a), is amended (1) by striking out "not less than five or" and inserting in lieu thereof "for not"; (2) by striking out "less than ten or"; and (3) by striking out "For provision relating to sentencing, probation, etc., see section 7237(d) of the Internal Revenue Code of 1954.".

SEC. 2. (a) Subsection (a) of section 7237 of the Internal Revenue Code of 1954, as amended, is amended (1) by striking out "not less than 2 or" and inserting in lieu thereof "for not"; (2) by striking out "not less than 5 or" and by inserting in lieu thereof "for not"; and (3) by striking out "not less than 10 or" and inserting in lieu thereof "for not".

(b) Subsection (b) of section 7237 of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(b) Sale or other transfer without written order.

"(1) Whoever commits an offense, or conspires to commit an offense, described in section 4705(a) or section 4742(a) shall be imprisoned for not more than 20 years and, in addition, may be fined not more than $20,000. For a second or subsequent offense, the offender shall be imprisoned for not more than 40 years and, in addition, may be fined not more than $20,000.

"(2) If any offender under paragraph (1) attained the age of 18 before the offense and—

"(A) the offense consisted of the sale, barter, exchange, giving away, or transfer of any narcotic drug to a person who had not attained the age of 18 at the time of such offense, or

"(B) the offense consisted of a conspiracy to commit an offense described in paragraph (A),

the offender shall be imprisoned not less than 5 or more than 40 years and, in addition, may be fined not more than $20,000."

SEC. 3. Subsection (d) of section 7237 of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(d) No suspension of sentence; no probation.

"Upon conviction of any offense the penalty for which is provided in subsection (b)(2) of this section or in subsection (c) or (i) of section 2 of the Narcotic Drugs Import and Export Act, as amended, the imposition or execution of sentence shall not be suspended and probation shall not be granted. Any person convicted of any such offense (including convictions in the District of Columbia) and sentenced to a definite term of years other than life shall be eligible for parole in accordance with the provisions of section 4202 of title 18 of the United States Code after such person has served for a period of not less than the mandatory minimum penalty prescribed by any such subsection for such offense. Any

such person so convicted and sentenced to a term of life shall be eligible for parole in accordance with such section 4202 after such person has served for a period of at least 15 years of such life sentence."

SEC. 4. (a) Chapter 402 of title 18 of the United States Code is amended by adding at the end thereof the following new section:

"§ 5027. Applicability to certain narcotic violators.

"Subject to the provisions of subsection (d) of section 7237 of the Internal Revenue Code of 1954, as amended, the provisions of this chapter shall be applicable to all persons otherwise eligible, who are convicted of violations of any Federal penal law relating to narcotics notwithstanding the fact that a mandatory penalty is prescribed for any such violation."

(b) The analysis of chapter 402 of title 18, United States Code, is amended by adding at the end thereof the following:

"527. Applicability to certain narcotic violators."

SEC. 5. Section 4209 of title 18, United States Code, is amended by adding at the end thereof the following new sentence: "Subject to the provisions of subsection (d) of section 7237 of the Internal Revenue Code of 1954, as amended, the provisions of this section shall be applicable to all persons otherwise eligible, who are convicted of violations of any Federal penal law relating to narcotics notwithstanding the fact that a mandatory penalty is prescribed for any such violations."

SEC. 6. (a) Chapter 301 of title 18 of the United States Code is amended by inserting immediately after section 4002, the following new section:

"§ 4002A. Use of State facilities for narcotic addicts.

"(a) For the purpose of providing for the confinement, care, treatment, and rehabilitation (including vocational rehabilitation) of persons held under the authority of any enactment of Congress who are narcotic addicts, or who are suffering from a mental or physical condition which might be helped by proper care, treatment, or rehabilitation (including vocational rehabilitation), the Director of the Bureau of Prisons is hereby given authority, in addition to other authority available to him, to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States and subdivisions, specially equipped to provide such care, treatment, or rehabilitation, will be made available, on a reimbursable basis, for the aforementioned purposes.

"(b) As used in this section, and sections 4082A and 4082B of chapter 305 of this title, the term 'narcotic addict' means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction. As used in this subsection, the term 'narcotic drugs' shall include the substances defined as 'narcotic drugs,' 'isonipecaine,' and 'opiate' in section 4731 of the Internal Revenue Code of 1954, as amended."

(b) The analysis of chapter 301 of title 18, United States Code, is amended by inserting immediately after "4002. Federal prisoners in State institutions; employment." the following:

"4002A. Use of State facilities for narcotic addicts."

SEC. 7. (a) Chapter 305 of title 18 of the United States Code is amended by inserting immediately after section 4082, the following new sections:

"4082A. Treatment authorized for certain persons committed to the custody of the Attorney General.

"(a) If the Attorney General determines that any person committed to his custody pursuant to section 4082 of this chapter is a narcotic addict, or is suffering from a mental or physical condition, and might be helped by proper care, treatment, or rehabilitation (including vocational rehabilitation), the Attorney General is hereby authorized, in addition to other authority available to him, to designate as the place of confinement for such person, any appropriate institution or other facility of the United States, or any appropriate institution or other facility made available pursuant to section 4002A of this title, which is specially equipped to provide such care, treatment, or rehabilitation. The Attorney General may order any such person transferred from any one such institution or facility to any other such institution or facility.

"(b) Whenever the Attorney General determines that any person confined in an institution or facility pursuant to a designation by the Attorney General

under subsection (a) of this section, or pursuant to an order of a United States court under section 4082B of this chapter, is no longer in need of such care, treatment, or rehabilitation, or that his continued confinement therein is no longer necessary or desirable, the Attorney General may transfer such person to any penal or correctional institution designated by the Attorney General to complete his original sentence. The time spent by such person in confinement in such institution or facility shall be considered as part of the term of his imprisonment.

"§ 4082B. Treatment authorized by the court for certain persons committed to the custody of the Attorney General.

"§ 4082B. In any case in which the court believes that a person convicted therein of violating a Federal penal law is a narcotic addict, or is suffering from a mental or physical condition, and might be helped by proper care, treatment, and rehabilitation (including vocational rehabilitation), the court may, after pronouncing sentence against such person, order the Attorney General to confine such person in an appropriate institution or facility in accordance with the provisions of section 4082A of this chapter."

(b) The analysis of chapter 305 of title 18, United States Code, is amended by inserting immediately after "4082. Commitment to Attorney General; transfer." the following:

"4082A. Treatment authorized for certain persons committed to the custody of the Attorney General.

"4082B. Treatment authorized by the court for certain persons committed to the custody of the Attorney General."

SEC. 8. (a) Chapter 311 of title 18 of the United States Code is amended by inserting immediately after section 4203, the following new section:

"§ 4203A. Use of certain public and private agencies for purposes of supervising certain parolees.

"(a) In any case in which a person confined in any institution or other facility in accordance with the provisions of section 4082A or 4082B of this title is thereafter authorized by the Board of Parole to be released on parole under section 4203 of this chapter, the Board may, in its discretion, impose as a condition to such release a requirement that the person be placed, during the period of his parole, under the supervision of an appropriate State, public or private agency, organization, or group, which, in the opinion of the Board is (1) qualified to supervise such person during the period of this parole; and (2) specially equipped to provide such care, treatment, rehabilitation, or aftercare as he might require during such period. The Board shall receive and consider any recommendation of the Attorney General which in his opinion would be helpful to the Board with respect to the parole disposition of any case pursuant to this section.

"(b) For the purposes of subsection (a) of this section, the Board of Parole is authorized to utilize the services and facilities of any State, agency, organization, or group referred to in subsection (a) in accordance with a written agreement entered into between such State, agency, organization, or group and the Board of Parole. Payment for such services and facilities shall be made in such amount as may be provided in such agreement."

(b) The analysis of chapter 311 of title 18, United States Code, is amended by inserting immediately after "4203. Application and release; terms and conditions." the following:

"4203A. Use of certain public and private agencies for purposes of supervising certain parolees."

S. 2115. A bill to provide financial assistance to the States to assist them in establishing treatment and rehabilitation services for drug abusers; to the Committee on Labor and Public Welfare, introduced by Mr. Kennedy of New York (for himself, Mr. Javits, Mr. Case, Mr. Ervin, Mr. Hart, Mr. Kuchel, Mr. Long of Missouri, Mr. Tydings, and Mr. Williams of New Jersey).

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—TREATMENT AND REHABILITATION SERVICES FOR DRUG ABUSERS

SECTION 101. This title may be cited as the "Drug Abusers Treatment Services Act".

SEC. 102. (a) For the purpose of financially assisting the several States in establishing, developing, and maintaining treatment and rehabilitation services for

drug abusers, there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the two succeeding fiscal years, the sum of $7,500,000.

(b) Of the amount appropriated pursuant to subsection (a) for each such fiscal year (1) not less than 80 per centum thereof shall be available for use by the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary") in (A) making grants under this title to assist any State (which has submitted and had approved a State plan as hereinafter provided in this title), in defraying expenses and other costs incurred by it in establishing, developing, and maintaining treatment and rehabilitation services for drug abusers (including the training of personnel necessary to operate such services and the conducting of statistical and biometric programs necessary for carrying out epidemiologic and longitudinal studies of drug addiction and abuse); and (B) providing technical assistance to such State in carrying out such services; and (2) not more than 20 per centum thereof shall be available for use by the Secretary in (A) making grants under this title to assist any nonprofit organization (which has submitted and had approved an application as hereinafter provided in this title) in defraying expenses and other costs incurred by it in establishing, developing, and maintaining such treatment and rehabilitation services as are referred to in clause (1) of this subsection; and (B) providing technical assistance to such organization in carrying out such services.

(c) Any sums appropriated pursuant to subsection (a) of this section shall remain available until expended for payments with respect to projects on which applications have been filed under section 105 or 106 of this title before July 1, 1968, and approved by the Secretary before July 1, 1969. The full amount (as determined by the Secretary) of any grant under this title shall be reserved from any appropriations available therefore; and payments on account of such grant may be made only from the amount so received.

SEC. 103. (a) Within six months after the enactment of this title, the Secretary shall issue such regulations, applicable uniformly to all the States, as he may determine necessary to enable him to carry out the provisions of this title. Such regulations shall include, among others, provisions prescribing the kinds of treatment and rehabilitation services for drug abusers for which grants may be made under this title, such as, but not limited to, detoxification or other medical treatment, physical therapy, family counseling, psychotherapy, vocational training, help in finding employment, or probation-type supervision.

(b) The regulations referred to in subsection (a) may include provisions requiring that (1) before approval of any application for a project pursuant to a State plan is recommended by any agency, an assurance shall be received, by the State filing such plan, from the applicant that a reasonable volume of treatment and rehabilitation services for drug abusers shall be made available to such drug abusers who are unable to pay for such services; and (2) each application filed by a nonprofit organization for financial assistance under clause (2) of subsection (b) of section 102 of this title contain an assurance that a reasonable volume of such services shall be made available to such drug abusers who are unable to pay for such services.

SEC. 104. (a) After the regulations referred to in section 103 have been issued, any State desiring to secure financial assistance under clause (1) of subsection (b) of section 102 of this title shall submit a State plan for carrying out the purposes of such clause. Such State plan must—

(1) set forth a program for providing for treatment and rehabilitation services for drug abusers which conforms with the regulations prescribed under section 103;

(2) designate a single State agency (referred to in this title as the "Agency") as the sole agency for supervising the administration of the plan;

(3) contain satisfactory evidence that the Agency will have authority sufficient to carry out such plan in conformity with this title;

(4) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(5) provide that the Agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

(6) provide for affording to every applicant for a grant for a project pursuant to a State plan an opportunity for hearing before the Agency;

(7) provide that the State will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) Any State desiring to submit a State plan as provided under subsection (a) shall submit such plan as a separate and distinct part of its State mental health plan submitted to the Public Health Service by the State's mental health authority in accordance with title III of the Public Health Service Act.

(c) The Secretary may approve any State plan (and any modification thereof) which is in substantial conformity with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

SEC. 105. (a) Any State, political subdivision of a State, or nonprofit organization desiring to secure financial assistance for any project for the treatment and rehabilitation of drug abusers pursuant to an approved State plan shall submit, through the Agency, an application for a grant under this title to assist it in carrying out such project. If any State, subdivision, or organization jointly participate in any such project, the application may be filed by one or more of the participants. The application shall set forth—

(1) the kinds of treatment and rehabilitation services which will be provided under the project with respect to which such application is filed;

(2) reasonable assurance that the applicant is legally qualified and is competent to provide such services;

(3) reasonable assurances that the applicant will meet the requirements, if any, for furnishing treatment and rehabilitation services to drug abusers who are unable to pay for such services; and

(4) such other information and assurances as the Secretary may, by regulation, require.

(b) The Secretary may approve any application filed under this section, if he finds that the application (1) is in substantial conformity with subsection (a) of this section and all applicable regulations issued pursuant to this title, (2) is in substantial conformity with the State plan approved under section 104 of this title, and (3) has been approved and recommended by the Agency. No application filed pursuant to this section shall be disapproved by the Secretary until he has afforded the applicant an opportunity for a hearing.

SEC. 106. (a) Any nonprofit organization desiring to securing financial assistance for any project for the treatment and rehabilitation of drug abusers as provided under clause (2) of subsection (b) of section 102 of this title shall submit to the Secretary an application for a grant under such clause to assist it in carrying out such project. If two or more such organizations jointly participate in such project, the application may be filed by one or more of the participants. The application shall set forth—

(1) the kinds of treatment and rehabilitation services which will be provided under the project with respect to which such application is filed;

(2) an assurance that the applicant is legally qualified and is competent to provide such services;

(3) reasonable assurances that the applicant will meet the requirements, if any, for furnishing treatment and rehabilitation services to drug abusers who are unable to pay for such services; and

(4) such other information and assurances as the Secretary may, by regulation, require.

(b) The Secretary may approve any application filed under this section, if he finds (1) that the application is in substantial conformity with the provisions of subsection (a) of this section and all applicable regulations issued pursuant to this title; and (2) after consultation with the Agency, that the application is not inconsistent with the State plan. No application filed pursuant to this section shall be disapproved by the Secretary until he has afforded the applicant an opportunity for a hearing.

(c) The Secretary may, by regulation, provide for regular reports to him by any recipient of a grant under this section.

SEC. 107. The payment of any grant to a State, political subdivision of a State, or nonprofit organization under this title may follow the approval by the Secretary of the application of such State, subdivision, or organization. Such payment may be made by the Secretary in advance or by way of reimbursement, and in such installments as he may determine, and shall be made on such conditions as he finds necessary to carry out the purposes of this title. Amounts paid

under this title with respect to any project covered by an application made under section 105 shall not exceed two-thirds of the cost of such project as determined by the Secretary.

SEC. 108. (a) There is hereby created an Advisory Committee on Drug Abuse (hereinafter referred to as the "Committee"), which shall consist of nine members appointed by the Secretary. Such members shall be appointed from among individuals concerned with the medical and social aspects of drug abuse and who are eminent in fields relating to the treatment and rehabilitation of drug abusers (including the field of research), such as psychiatry, psychology, general medical practice, pharmacology, internal medicine, vocational training, correctional rehabilitation, and law enforcement. Each member of the Committee shall hold office for a term of 4 years, except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and (2) the terms of the members of the first Committee appointed shall expire, as designated by the Secretary at the time of appointment, as follows: three at the end of 16 months after their appointment, three at the end of 32 months after their appointment, and three at the end of 4 years after their appointment.

(b) It shall be the duty of the Committee to—

(1) advise, consult with, and make recommendations to the Secretary on matters relating to the administration of this title;

(2) assist States desiring financial assistance under this title in the preparation and filing of their State plans; and

(3) assist the Secretary in his carrying out of the purposes of section 301 of the Public Health Service Act with respect to narcotics by encouraging States, local agencies, laboratories, public and nonprofit agencies, and other qualified individuals to engage in research projects and collaborative studies, on a long-term contract basis, into all aspects of drug abuse with a view to obtaining information, facts and other data necessary to enable the various governmental entities and private agencies to meet and combat the many problems resulting from drug abuse.

(c) Members of the Committee, not otherwise in the employ of the United States, while attending meetings of the Committee or while otherwise serving at the request of the Secretary, shall be entitled to receive compensation, at a rate to be fixed by the Secretary, but not exceeding $75 per diem, including travel time; and while away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons in the Government service employed intermittently.

(d) The Committee shall elect a chairman from among its members, and shall be provided, by the Secretary, with such technical, consultative, clerical, and other assistance as he determines necessary to enable it to carry out its duties under this section.

SEC. 109. (a) Whenever the Secretary, after reasonable notice and opportunity for hearing to the Agency, finds—

(1) that the Agency is not complying substantially with the provisions required by subsection (a) of section 104 to be included in its State plan, or with regulations under this title;

(2) that any assurance required to be given in an application filed under subsection (a) of section 105 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out the treatment and rehabilitation services approved by the Secretary under section 105;

the Secretary may forthwith notify such Agency that no further payments will be made under this title for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph 1, 2, or 3 of this subsection; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments in connection with such State plan may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurances or services, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

(b) Whenever the Secretary, after reasonable notice and opportunity for hearing to any nonprofit organization, which is the recipient of a grant under clause (2) of subsection (b) of section 102 of this title, finds—

(1) that such recipient is not complying substantially with the provisions required by section 106 of this title to be included in its application for such grant, or with regulations under this title;

(2) that any assurance required to be given in such application filed under section 106 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out the treatment and rehabilitation services approved by the Secretary under section 106;

the Secretary may forthwith notify the recipient that no further payments will be made under this title for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), or (3) of this subsection; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments under this title to such recipient may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurances or services, as the case may be) or, if such compliance (or other action) is impossible, until the recipient repays the moneys to which it was not entitled.

SEC. 110. (a) In providing technical assistance pursuant to this title, the Secretary is authorized to make studies with respect to matters relating to the treatment and rehabilitation of drug abusers, including the effectiveness of projects financed in whole or in part by grants made pursuant to this title, to cooperate with and render technical assistance to States, political subdivisions of States, and nonprofit organizations with respect to such matters, and to provide short-term training and instruction in technical matters relating to the treatment and rehabilitation of drug abusers.

(b) The Secretary is authorized to collect, evaluate, publish, and disseminate information and materials relating to studies conducted pursuant to this title, and to such other matters involving the treatment and rehabilitation of drug abusers as the Secretary may determine feasible. The Secretary may, to the extent he determines appropriate, make such information and materials available to the general public or to any agency or other organization concerned with, or engaged in, the treatment and rehabilitation of drug abusers.

SEC. 111. In any case in which a State is dissatisfied with the actions of the Secretary under section 104(c), 105(b), or 109(a), or in which a nonprofit organization is dissatisfied with his actions under section 106(h) or 109(b), such State or organization, as the case may be, may appeal to the United States court of appeals for the circuit in which such State or organization is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

SEC. 112. As used in this title, the term—

(1) "State" shall include the District of Columbia; and

(2) "drug abuser" means any person who repeatedly uses, on a periodic or continuous basis, for their psychotoxic effects alone and not as therapeutic media prescribed in the course of legitimate medical treatment, any drug or drugs capable of altering or affecting, to a substantive degree, the consciousness, mood, motivation, or critical judgment of an individual, or the psychomotor coordination or the perception of the auditory or visual sense of an individual. Such drugs shall include, without limitation thereto, the opiates, cocaine, marihuana, barbiturates, and amphetamines, but shall not include alcohol.

TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

SEC. 201. Section 341 of the Public Health Service Act (58 Stat. 682) is amended (1) by inserting immediately after "discipline of persons" the following: "who are physically or psychologically"; and (2) by inserting at the end of the first paragraph thereof the following: "Such hospitals shall, in addition to providing such care and treatment, engage in research, training, and demonstration in the techniques of treatment and social rehabilitation of addicts."

SEC. 202. Paragraph (j) of section 2 of the Public Health Service Act is amended by adding at the end thereof the following: "any drug which contains any quantity of (A) barbituric acid or any of the salts of barbituric acid, or (B) any derivatives of barbituric acid which has been designated by the Secretary under section 502(d) of the Federal Food, Drug and Cosmetic Act as habit forming; any drug which contains any quantity of (A) amphetamine or any of its optical isomers; (B) any salt of amphetamine or any salt of an optical isomer of amphetamine, or (C) any substance which the Secretary, after investigation, has found to be, and by regulation designated as, habit forming because of its stimulant effect on the central nervous system; any drug which contains any quantity of a substance which the Secretary, after investigation, finds, and by regulation designates as a substance which (A) affects or alters to a substantive extent, consciousness, the ability to think, critical judgment, motivation, mood, psychomotor coordination, sensory perception, and (B)(1) is substantially involved in drug abuse ("drug abuse" being deemed to exist when drugs are used for their phychotoxic effects alone and not as therapeutic media prescribed in the course of medical treatment or when they are obtained through illicit channels), or (ii) has a substantial potential for such abuse by reason of the similarity of its effects to that of a drug already subject to this paragraph;".

SEC. 203. Paragraph (k) of section 2 of the Public Health Service Act is amended by adding at the end thereof the following: "or any person who repeatedly uses, on a periodic or continuous basis, for their psychotoxic effects alone and not as therapentic media prescribed in the conrse of legitimate medical treatment, any drug or drugs capable of altering or affecting, to a substantive degree, the consciousness, mood, motivation, or critical judgment of an individual, or the psychomotor coordination or the perception of the auditory or visual sense of an individual;".

S. 2116. A bill to provide financial assistance to the States to assist them in the construction of facilities for the treatment and rehabilitation of drug abusers; to the Committee on Labor and Public Welfare, introduced by Mr. Javits (for himself, Mr. Kennedy of New York, Mr. Case, Mr. Ervin, Mr. Hart, Mr. Kuchel, Mr. Long of Missouri, Mr. Tydings, and Mr. Williams of New Jersey):

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Drug Abusers Treatment Facilities Act".

SEC. 2. (a) For the purpose of financially assisting the several States in the construction of facilities for the treatment and rehabilitation of drug abusers, there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the two succeeding fiscal years, the sum of $15,000,000.

(b) Sums appropriated pursuant to subsection (a) shall be available for use by the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary") in (1) making grants under this Act to assist financially any State (which has submitted and has approved a State plan as hereinafter provided in this Act) in the construction of facilities for the treatment and rehabilitation of drug abusers; and (2) furnishing technical assistance to such State in designing, locating, and constructing such facilities.

(c) Sums appropriated pursuant to subsection (a) of this section shall remain available until expended for payments with respect to projects on which applications have been filed under section 5 of this Act before July 1, 1968, and approved by the Secretary before July 1, 1969. The full amount (as determined by the Secretary) of any grant for a project under this Act shall be reserved from any appropriations available therefor; and payments on account of such grant may be made only from the amount so reserved.

SEC. 3. (a) Within six months after the enactment of this Act, the Secretary shall issue such regulations, applicable uniformly to all the States, as he may

determine necessary to enable him to carry out the provisions of this Act. Such regulations shall include, among others, provisions prescribing—

(1) general standards of construction for any such facility the construction of which is financed at least in part from a grant under this Act; and

(2) the kinds of facilities and services needed to provide adequate treatment and rehabilitation for drug abusers.

(b) The regulations referred to in subsection (a) may include provisions requiring that (1) before approval of any application for a project pursuant to a State plan is recommended by any Agency, an assurance shall be received, by the State filing such plan, from the applicant that a reasonable volume of treatment and rehabilitation services for drug abusers shall be made available to such drug abusers who are unable to pay for such services.

SEC. 4. (a) After the regulations referred to in section 3 have been issued, any State desiring to secure financial assistance under section 2 of this Act shall submit a State plan for carrying out the purposes of such section. Such plan must—

(1) set forth a program for construction of facilities for the treatment and rehabilitation of drug abusers which conforms with the regulations prescribed under section 3;

(2) designate a single State agency (referred to in this Act as the "Agency") as the sole agency for supervising the administration of the plan;

(3) contain satisfactory evidence that the Agency will have authority sufficient to carry out such plan in conformity with this Act;

(4) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(5) provide that the Agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

(6) provide for affording to every applicant for a grant for a project pursuant to a State plan an opportunity for hearing before the Agency;

(7) provide that the State will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) Any State desiring to submit a State plan as provided under subsection (a) shall submit such plan as a separate and distinct part of its State mental health plan submitted to the Public Health Service by the State's mental health authority in accordance with title III of the Public Health Service Act.

(c) The Secretary may approve any State plan (and any modification thereof) which is in substantial conformity with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

SEC. 5. (a) Any State, political subdivision thereof or nonprofit organization desiring to secure financial assistance under this Act for any project for the construction of facilities for the treatment and rehabilitation of drug abusers pursuant to an approved State plan shall submit, through the Agency, an application for a grant under this Act to assist it in carrying out such project. If any State, one or more political subdivisions thereof, or one or more nonprofit organizations jointly participate in any such project, the application may be filed by one or more of the participants. The application shall set forth—

(1) a description of the site for such project;

(2) plans and specifications for such project in accordance with the regulations prescribed by the Secretary under subsection (a) of section 3 of this Act;

(3) reasonable assurances that title to such site is or will be vested in one or more of the applicants filing the application;

(4) reasonable assurances that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed;

(5) reasonable assurances that the applicant will meet the requirements, if any, for furnishing treatment and rehabilitation services to drug abusers who are unable to pay for such services.

(6) such other information and assurances as the Secretary may, by regulation, require; and

(7) reasonable assurances that all laborers and mechanics employed by contractors or subcontractors in the performance of work on construction of the project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a–276a–5); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

(h) The Secretary may approve any application filed under this section if he finds that the application (1) is in substantial conformity with subsection (a) of this section and all applicable regulations issued pursuant to this Act; (2) is in substantial conformity with the State plan approved under section 4 of this Act; and (3) has been approved and recommended by the Agency. No application filed pursuant to this section shall be disapproved by the Secretary until he has afforded the applicant an opportunity for a hearing. Any amendment of an application approved under this Act shall be subject to approval in the same manner as the original application.

SEC. 6. The payment of any grant to a State, political subdivision, or nonprofit organization under this Act may follow the approval by the Secretary of the application of such State, subdivision or organization. Any grant made pursuant to this Act for the construction of a project in any fiscal year shall include such amounts as the Secretary determines to be necessary in succeeding fiscal years for completion of the Federal participation in the project as approved by him. Payment of a grant may be made in advance or by way of reimbursement, and in such installments as may be determined by the Secretary, and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of this Act. Amounts paid under this Act with respect to any project for the construction of a facility shall not exceed two-thirds of the construction costs of such facility as determined by the Secretary.

SEC. 7. Whenever the Secretary, after reasonable notice and opportunity for hearing to the Agency, finds—

(1) that the Agency is not complying substantially with the provisions required by subsection (a) of section 4 to be included in its State plan, or with regulations under this Act;

(2) that any assurance required to be given in an application filed under subsection (a) of section 5 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 5; the Secretary may forthwith notify such Agency that no further payments will be made under this Act for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph 1, 2, or 3 of this subsection; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments in connection with such State plan may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurances or plans and specifications, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

SEC. 8. If any facility with respect to which funds have been paid under this Act shall, at any time within twenty years after completion of its construction—

(1) be sold or transferred to any nonpublic organization; or

(2) cease to be used for the purposes for which it was constructed, unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant from the obligation to continue such facility for the purpose of providing treatment for drug abusers;

the United States shall be entitled to recover from the recipient of such funds an amount bearing the same ratio to the then value (as determined by agreement of the parties or by action brought in the United States district court for the district in which the facility is situated) of the facility, as the amount of the Federal participation bore to the cost of construction of the facility.

SEC. 9. If any recipient of a grant under this Act is dissatisfied with any action taken by the Secretary under section 4(c), 5(h), 7, or 8 of this Act, such recipient may appeal to the United States court of appeals for the circuit in which such recipient is located, by filing a petition with such court within sixty days after

such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

SEC. 10. (a) The Secretary is authorized to appoint such technical or other advisory committees as he deems necessary to advise him in connection with carrying out the provisions of this Act.

(b) Members of any such committees not otherwise in the employ of the United States, while attending meetings of their committee, shall be entitled to receive compensation at a rate to be fixed by the Secretary, but not exceeding $75 per diem, including travel time; and while away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons in the Government service employed intermittently.

SEC. 11. As used in this Act, the term—

(1) "State" shall include the District of Columbia;

(2) "drug abuser" means any person who repeatedly uses, on a periodic or continuous basis, for their psychotoxic effects alone and not as therapeutic media prescribed in the course of legitimate medical treatment, any drug or drugs capable of altering or affecting, to a substantive degree, the consciousness, mood, motivation, or critical judgment of an individual, or the psychomotor coordination or the perception of the auditory or visual sense of an individual. Such drugs shall include, without limitation thereto, the opiates, cocaine, marihuana, barbiturates, and amphetamines, but shall not include alcohol;

(3) "facilities" means buildings or other facilities which are operated for the primary purpose of assisting in the treatment and rehabilitation of drug abusers by providing, under competent professional supervision, detoxification or other medical treatment, physical therapy, family counseling, psychotherapy, vocational training, help in finding employment, or other services. The term "facilities" shall include, among others, facilities for medical care, laboratories, community clinics, halfway houses, sheltered workshops, and camps;

(4) "construction" includes the creation of new buildings, acquisition, expansion, remodeling, and alteration of existing buildings, and payment of architect's fees. The term "construction" does not include the cost of offsite improvements and acquisitions of land.

Mr. JAVITS. Mr. President, I yield now to my colleague, the Senator from New Jersey, Mr. Case.

Mr. CASE. Mr. President, I am happy to join with my colleagues from New York and several other States in sponsorship of this legislation to advance our battle against the tragedy of narcotics addiction.

Far too many of our citizens are the victims of this terrible fate; far too much time has passed without the achievement of lasting results in the campaign against this age-old affliction.

It is my belief that if these bills can be enacted we can make important strides in the direction of returning thousands of addicts to normal, useful lives.

I am particularly pleased that these measures have recognized the work being done by private, nonprofit organizations in the field of treatment. By providing these organizations with working capital to continue and improve their efforts we will be assured of both balance and additional strength in this good fight.

But I would emphasize that treatment is not the last step in the rehabilitation of the narcotics addict. The type and quality of aftercare are crucial. Here we have something less than a spectacular record. According to available estimates the relapse rate of drug addicts has ranged up to 90 percent. The chief problem seems to be in the addict's difficulty, after release from a hospital or rehabilitation center, in making a successful adjustment to his social environment.

One of the important purposes of our legislation is to deal with this particular phase of the problem and it is my hope that the committees which take up these bills will give it the most careful attention.

Mr. JAVITS. Mr. President, may I express our joint gratitude to the distinguished Senator from New Jersey.

Senator JAVITS. The real different between the California and New York programs lies in a difference of 2 years' progress. California passed and made its statute effective in 1961. New York passed and made its statute effective finally in 1963, and naturally there is a timelag before the program is fully operative.

Secondly, there is a somewhat greater emphasis in New York upon decentralization of the treatment facilities. California has a single rehabilitation center at Carona, Calif. New York is developing, and is now financing six medical treatment centers which represent, incidentally, a memorial to a very good friend of mine, and I think of the other New York Members here, Dr. Paul Hoch, who is the director of the Department of Mental Hygiene of the State of New York, before he passed away a short time ago, and who was so successful in reducing the population of the mental hospitals so as to make available quite a few beds which are now being diverted for treatment of addicts.

The budget for New York State for fiscal year 1966 calls for six treatment units in State hospitals, a total of 500 beds, scattered throughout the State. That distinguishes New York in one respect from California, which has a centralized facility.

Another respect in which we are different from California is in our use of aftercare clinics in the locality in which the addict lives. This is a hotly contested medical point, but I thoroughly agree with Senator Kennedy, it is something for the doctors and psychiatrists to decide. The important factor is that our bills, and the Celler bill, provide Federal assistance to stimulate the development of treatment facilities and services so that the State efforts can be expanded to meet the need; whereas the administration proposal does not include such assistance.

In summing up, I would say that I favor the Celler bill, which is essentially comprised of our bills in the Senate and has been properly consolidated here by Congressman Celler. I favor the expansion of the reach of the legislation in the manner that I have described to practically any criminal who is a narcotics addict, provided that I would shift the option from one who is charged with other than a narcotics offense to the court. I hope very much the bill will be expanded in that way.

I favor very strongly the idea of working with the States. The States of California and New York have shown promise in this regard. I believe that the States need Federal money, not only for personnel to administer rehabilitative treatment of addicts, which is the subject of one of our bills, but also for facilities. This would

mean not only the purchase and construction of new facilities—with $15 million annually you can't buy that much bricks and mortar—but primarily helping the States and private nonprofit groups to rehabilitate, or make available, facilities which could be freed from other purposes.

I have already spoken of mental health facilities in this regard. It is also a fact, for example, that beds formerly assigned to tuberculosis patients are becoming increasingly available as tuberculosis becomes the subject of a different and much faster cure than it heretofore had. We must help the States, therefore, to convert facilities which they have, to use for the purposes which we are discussing.

This bears very directly on the question of the effectiveness of the Federal hospitals facilities at Lexington, Ky., and Fort Worth, Tex. These hospitals are in themselves fine facilities and everyone appreciates them greatly. However, apart from the prison population, a person stays or goes pretty much as he pleases in those institutions. Furthermore, he is quite far from home, so that, although an addict may be fine while he is there, when he goes home 500 or 1,000 miles away, he is again alone in the world which bred his addiction, and he goes back to the narcotic habit. So the idea of local treament as an integral part of the medical system, of aftercare in the ways I have described, represents the fundamental philosophy incorporated in these bills.

Finally, Mr. Chairman, the question of research has been raised. There are very few fields which have suffered as badly as this has from lack of research. Until many of us got interested in this field, practically nothing had been done. The Secretary of Health, Education, and Welfare and I recently exchanged correspondence which also appears in the Congressional Record of June 9, 1965. In the course of that exchange, he assured me that funds from the mental health research program under section 303 of the Public Health Service Act are now available for research in narcotics addiction. Although I had heretofore introduced legislation for this purpose, I believe it is no longer necessary in that the Department now says narcotics addiction will fit directly into the National Institute of Mental Health research program.

There is one other important, complementary point regarding research. I very much hope that the Narcotics Bureau will go to some pains to enlighten the medical profession of the Nation as to what it may and may not do with respect to research in the field of narcotics addiction. Whether they are right or not—and the Narcotics Bureau says they are not right—the doctors have felt they are materially inhibited from conducting research by the fear of losing their licenses, or even being prosecuted, if they permit the administration of drugs to an addict even in the course of experimentation. This is a very trying subject, and could easily inhibit very important research efforts.

I am not quarreling with the Narcotics Bureau. I think it has tried to make its views clear, but I do not think the message has gotten through to the medical profession. I hope very much that pains will be taken to do that, through clarification of the Bureau's regulations in consultation with medical groups, so we may have the broadest

participation in the research effort which now seems to be able to get off the ground because of the new attitude of the Health, Education, and Welfare Department.

I would add one other point about existing sources of Federal funds. I offered an amendment to the Community Mental Health Centers Construction Act of 1963, which the Senate accepted and which was incorporated in the conference report, to permit narcotics addiction treatment facilities to be included as a part of a mental health center under the act. Since this program is just beginning to be implemented, it is difficult to state with certainty how far that provision will take us, particularly in the large metropolitan areas where the addiction problem is greatest and where, at the same time, a single treatment facility may well be insufficient by itself. Our bills call for coordinating plans for narcotics facilities with a State's mental health plan.

Thank you very much.

Mr. ASHMORE. Senator, do you have in mind the sum of money that should be used for additional facilities?

Senator JAVITS. Our bills propose a 3-year program providing $15 million a year for facilities and $7.5 million a year for treatment services, both in-hospital and aftercare, to be matched one-third to two-thirds by the States. I am very hopeful that perhaps HEW will come up with some testimonay as to precisely how they feel about these amounts, which our surveys indicated are best related to the needs of the States, especially those with a great incidence of narcotics addiction.

Mr. ASHMORE. Last year it was indicated by HEW we did not need more facilities, that the facilities we have, working in collaboration with the various States, can handle these matters.

Senator JAVITS. I agree with HEW about that in one respect. I have testified that the funds for provision of facilities would be spent primarily for conversion rather than original construction. Certainly the amounts involved themselves would indicate you cannot have very much original construction, if any. I also believe that reconversion of available bed space for this purpose would result in a faster effort in this regard. Both Senator Kennedy and I feel this way about the facilities issue. I assume that, when the chairman mentions facilities, he does not exclude the treatment services, which relate to outpatient and aftercare and so forth.

Mr. ASHMORE. I think the outpatient and aftercare program is most vital. I do not know what sort of facilities might be needed for that purpose but certainly sympathy and close contact with these people after they are released and return to their normal life is undoubtedly one of the most important aspects of the whole program.

Senator JAVITS. Mr. Chairman, I hope that whatever the committee does on facilities, it will also bear in mind the provision I have mentioned with regard to the Mental Health Centers Construction Act. I think it would be very important to take cognizance of this. We have found, particularly in the Senate Committee on Labor and Public Welfare, that we are constantly plagued with a great number of apparently overlapping programs, and we must be alert to the need for coordination. We ran into a situation just yesterday in which

there were about 40 existing programs in a particular education field in which we were adding another program. This does not mean the new program was not necessary—it was—but it had not been related to the 40-odd other programs which are going at the same time.

Mr. ASHMORE. You mentioned with regard to funds for facilities that probably funds would be available from the Department of Health, Education, and Welfare.

Senator JAVITS. That is correct in regard to research.

Mr. ASHMORE. Do you have that quotation there?

Senator JAVITS. Yes, and I would like to suggest to the chairman that the committee look at the exchange of correspondence with the Department of Health, Education, and Welfare in the Congressional Record of June 9, 1965, at page 14576 et seq.

Mr. ASHMORE. Would that be under NIH?

Senator JAVITS. That would come out of the funds of the National Institute of Mental Health, one of the NIH Institutes. For a long time they did not agree with us that support for narcotics research could come from NIMH, but now they do, which obviates any necessity for special legislation.

Mr. ASHMORE. Mr. Gilbert.

Mr. GILBERT. I thank the distinguished Senator from New York for his testimony this morning. It was a very thoughtful statement. I am particularly interested in the bill introduced by the distinguished chairman of the Judiciary Committee, Mr. Celler. I wonder if you have any figure to determine the number of people that would be affected in the event that this bill were adopted.

Senator JAVITS. My assistant tells me there are approximately 800 convictions a year in the Federal courts for narcotics crimes so that it would certainly be applicable there. I would add to that the following: I have heard from the judges of what was formerly the Court of General Sessions in New York County, now the supreme court, which has probably the most congested docket in the world, that approximately 30 percent of those arraigned before them for felonies are narcotics addicts. If you get into that field you are getting to thousands every year because, as you know, there are literally thousands of arraignments in the criminal part of the supreme court in a populous county like New York.

I would say, as an order of magnitude, that you would be dealing in the early stages of any such program as this, with something in an order of magnitude of 5,000 to 10,000 a year. That would be an order of magnitude, considering the fact you have a reported 100,000 addicts in the country. And my feeling is, based on this information as to the tremendous incidents of narcotics in major crimes, that you have to be prepared for an order of magnitude of 5,000.

Mr. GILBERT. I am curious about these figures. Of course the bill which you envision stops at the door of the Federal level so that you are not getting at the large corps of addicts that could be affected by this legislation.

Senator JAVITS. I agree with that in regard to our civil commitment and postconviction sentencing bills, which can, and do, only reach the Federal courts. But they would be reached through our bills to aid private, nonprofit facilities. In that way you will be dealing with numbers of the size I am talking about and, potentially, even larger numbers.

I would like to add that I have no pride of authorship or even pride of contention in any aspect of this matter, since so many people have collaborated in bringing it to the present phase. But I think the committee should not neglec our protgram for aid to facilities and services giving flexibility to use the funds available for services or for facilities or for any of the broad range of things we are talking about in our two bills for facilities and services. I would hope the amount of funds would not be reduced. In that way I think you will be getting at the bulk of those addicted. The way you will do the most good, as has been properly pointed out, is by what you stimulate the State and privateg roups to provide as well as through the medical philosophy of the Federal Government.

So I would suggest to the committee to allow for facilities or reconversion of facilities but not tie down any money for that field that could be used for other fields.

Mr. GILBERT. Is it your idea this should be done on an outright grant or matching?

Senator JAVITS. Matching; Senator Kennedy's bill and mine are primarily on a matching basis.

Mr. GILBERT. I would expect many of the States would not be interested in the program because of the financial aspect.

Senator JAVITS. I would expect some of them would not be interested because they do not have a concentration of addicts. As the chairman said, we undoubtedly have the problem in the District of Columbia and in other metropolitan centers, but the greatest concentration is in New York.

There are some extraordinary efforts being made of a voluntary character, and we should not exclude these tremendous voluntary efforts. The State of New York budget provides assistance for neighborhood groups, halfway houses, and so on that are operating in the Harlem area and other areas. There is a group called Synanon, a sort of "Narcotics Anonymous," about which a book and many articles have been written. The people engaged in that type of effort are entitled to our thanks and gratitude, and we should not neglect collaboration with these organizations. I hope very much we will not overlook that sort of effort, which is helping very materially.

Mr. GILBERT. I have heard of this organization. I think our citizens are becoming more and more aware of the serious nature of this problem.

Mr. ASHMORE. Will the gentleman yield?

Have any of the foundations put any money in this research?

Senator JAVITS. I do not believe the foundations have themselves entered into research. There is research being conducted by Dr. Marie E. Nyswander and others in the New York area and there is some research being done in the Detroit area also. I think the foundations have participated in the area of treatment by voluntary organizations. In fact, these organizations largely depend upon voluntary contributions.

May I, Mr. Chairman, offer for the record at this point the budget of the New York State Department of Mental Health for Narcotic Administration, Treatment, and Research for fiscal year 1965–66?

Mr. ASHMORE. Yes. It will be made a part of the record at this point.

(The budget referred to follows:)

Budget of the New York State Department of Mental Hygiene for Narcotic Administration, Treatment, and Research for fiscal year 1965–66

	Amount	Remarks
1. Administration	$151,485	Includes 15 additional positions principally in professional and technical areas.
2. Treatment services:		
For the operation of 6 treatment units in State hospitals, a total of 500 beds—Buffalo, Utica, Middletown, Manhattan, Pilgrim, and Central Islip.	2,426,096	These have been under operation for 2 years. Includes 60 new positions.
2 additional treatment units, 75 beds each, Bronx and Brooklyn.	754,730	Includes 156 new positions.
New York City After Care Clinic	180,954	This has been in operation for 2 years.
Bronx After Care Clinic	216,735	Includes 23 new positions.
Brooklyn After Care Clinic	205,000	New—Rental of facilities and an estimated 60 positions.
Queens After Care Clinic	205,000	Do.
3. Shared cost of New York City outpatient clinic	100,000	New—50 percent cost.
To New York City Mental Health Board for housing of patients.	450,000	New—100 percent cost.
For assistance of neighborhood groups	300,000	New.
For operation of halfway houses	210,000	Do.
For a sheltered workshop	50,000	Do.
4. Research: Research study, including 55-bed inpatient unit	530,584	This has been in operation for 2 years.
Total	5,789,584	

Senator JAVITS. The total is not inconsiderable, $5,789,584.

Mr. GILBERT. May I inquire with respect to the aftercare treatment. I think this perhaps goes to the heart of the entire problem, in order to prevent the addict from slipping back into his habit. This, to me, is as important if not more so than the initial approach of medical care. I think perhaps we ought to set up these halfway houses and do something more in this area because if we are going to permit this person who has received the treatment to return immediately to his own environment, I am fairly certain that statistics will show over 99 percent return to the narcotics habit.

Senator JAVITS. The crime bill in the country is estimated at $25 billion or more a year, that is, the bill for crimes of violence, felonies, et cetera. And I would say certainly a fair estimate of the proportion of that which is due to addiction would be somewhere in the area of one-fifth or one-fourth. That indicates how much is at stake if we do something effective about narcotics addiction.

Mr. GILBERT. I have no further questions.

Mr. ASHMORE. Mr. King.

Mr. KING. Senator Javits, I welcome you before our subcommittee and thank you for your testimony. I wanted to ask just a couple questions.

Can you tell us the status of these bills in the Senate? Are they before your committee now?

Senator JAVITS. Yes. Two are pending before the Judiciary Committee and two are pending before the Committee on Labor and Public Welfare. I am on both of those committees.

Mr. KING. Can you tell us when they will get out of committee?

Senator JAVITS. We will work hard on that. They were just introduced a month ago. Departmental reports have not yet been received.

Mr. KING. You spoke about $15 million annually. According to the figures presented to us here, there are about 1,900 cases that come

in Federal court and about 800 or 900 of those would be eligible for this treatment under your bill and Congressman Celler's bill. That would mean we would be spending $15 million to rehabilitate about 800 people. Is that correct?

Senator JAVITS. No; that is not correct.

Mr. KING. Will you explain it?

Senator JAVITS. I will, of course. The aid to the States for treatment would relate to everyone whom the States treat, to wit, those charged or convicted under the State law as well as those eligible within Federal courts jurisdiction. In other words, we are first trying to establish in the Federal penal laws regarding addicts charged with Federal crimes the philosophy already incorporated in the New York and California laws regarding addicts charged with State crimes. That is in S. 2113 and 2114, the pretrial civil commitment and post-conviction sentencing bills. S. 2115 and 2116, spell out what you do about treating addicts generally. What we propose to do about it is provide facilities and services for treating and rehabilitating all those who are addicts, including narcotics addicts charged with crime under State law and those who are not charged with crime, either State or Federal. In the latter two bills we are trying to help the States to deal effectively with addiction using the kind of programs that have been started in New York and California.

Mr. KING. Do you not think we are dealing with about four States that have most of the violations, and do you not think their problems should be financed by them rather than by all of the States in the United States?

Senator JAVITS. No; and I will tell you why. There is much too much mobility in the narcotics problem to permit it to be treated solely in that way. Beyond that, I think the States have the right to say to the Federal Government that heroin and other drugs of the character are coming into the United States from abroad in violation of a responsibility of the United States and not of the States. It has been testified, and I think quite properly, that if you wanted to stop the flow of these narcotics in the United States it would probably take the whole Army, Navy, and Air Force. We will commit ourselves in every conceivable way to stopping the flow by international treaties—unhappily, it will not help in the case of Red China, which is one source—and by protests to cooperating countries. But we must remember that it is the United States and not the States that has this responsibility in the first instance. And the Federal Government has undertaken this responsibility for decades. Therefore, I think the States have a right to turn to us and say, "OK, perhaps we should not blame you for this but somehow or other we need some help to deal with a problem because the United States has found it impossible to keep this contraband out of the country."

Mr. KING. Do you believe we could use existing facilities?

Senator JAVITS. Oh, yes. Congressman, take a look at any of our other programs, such as the Mental Health Centers Construction Act or any of our other mental health efforts, and compare them with what we are talking about here.

Mr. KING. It is merely a foot in the door. It is $15 million this year but how much will it be next year?

Senator JAVITS. There are many facilities which can be converted and supplemented for this purpose. There is a great deal that is being done in the other fields that impinge on this, such as mental health, and that is why I suggest that this be very carefully watched. But I do think this is a problem that is not vulnerable to the foot-in-the-door argument. In the first place, the number of people involved is not that great, thank God.

Mr. KING. You spoke about this being the option of the judge.

Senator JAVITS. Yes.

Mr. KING. Do you think the prosecuting attorney should join in this?

Senator JAVITS. Of course, it should be the option of the United States, as it were, as represented by the Federal court and the U.S. attorney.

Mr. KING. Is that in your bill?

Senator JAVITS. The court, in our bills, has the discretion and I think it would be perfectly proper that that should be shared with the prosecuting attorney.

Mr. KING. Thank you.

Mr. ASHMORE. Mr. Senner.

Mr. SENNER. I would like to join my colleagues in praising the distinguished Senator from New York for his fine statement.

I am interested in the halfway houses. I am not too familiar with them but I understand there are halfway houses that would deal in the drug addicts rehabilitation program through people employed by the States?

Senator JAVITS. Yes.

Mr. SENNER. Do we have difficulty with the Bureau of Narcotics' interpretation of administration of drugs to a drug addict in trying to overcome a sociological or emotional problem?

Senator JAVITS. I think the answer to that would be "Yes," in the sense that attorneys often say the facts are not what they are but what the judge thinks they are. The doctors do not seem to have clearly before them the permissible limits of their activities, and I feel there is some problem of communication. Despite a case decided by the Supreme Court a long time ago, the *Linder* case, there have been prosecutions of doctors since then, which have scared doctors throughout the country. Now the Narcotics Bureau feels there is no reason for their fear, but the doctors do not think so. I have expressed the plea that the situation be made very clear to the doctors by the Bureau in some organized way so that they would feel free to participate in legitimate activities of the type to which you refer. The fact is that they are reluctant to do so.

Mr. SENNER. Do you think the Congress should do anything to clarify this situation?

Senator JAVITS. I have personally asked the Narcotics Bureau to revise its regulations on this score. The Narcotics Bureau says it is not revising them on this score but is revising them and has asked us to wait and see, and I believe in the strange way we have of getting things done in this manner. If there were a feeling expressed on the part of this committee, I think it would make a contribution to getting it done.

Mr. SENNER. In my State of Arizona some people are opposed to having narcotics addicts housed near mentally unbalanced people and others.

Senator JAVITS. Mr. Senner, you are absolutely right. I think that by endorsing on the Federal level the basic philosophy of treatment of addiction as an illness the Congress will contribute to overcoming this. For your own information you might study the experience of the late Dr. Hoch, in lessening the security precautions taken in regard to mental patients in the State of New York and the tremendous benefits in the number of people released which his policy brought about. State authorities should study that experience very carefully.

Mr. SENNER. One last question: There have been some divergent opinions as to whether the Bureau of Narcotics' revenue aspect should be transferred to the Department of Justice and the Department of Health, Education and Welfare on the logic it is both a legal and health problem rather than a revenue problem. Will you comment on that?

Senator JAVITS. The enforcement aspects, such as those against contraband and so on, have been there a long time. I think Mr. Giordano, the present head of the Bureau of Narcotics, is very anxious to participate. I see no difficulty in all three agencies doing their jobs in cooperation with each other. I think at the moment I would not disturb that.

Mr. SENNER. Thank you.

Mr. ASHMORE. Mr. Hungate.

Mr. HUNGATE. Senator Javits, I too want to join my colleagues in thanking you for your able presentation today.

In the Celler bill, page 17, section 10, it provides—

there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the 2 succeeding fiscal years, the sum of $15 million.

Would that be construed as one $15 million?

Senator JAVITS. $15 million per year.

Mr. HUNGATE. For 3 years?

Senator JAVITS. Yes.

Mr. HUNGATE. That is all.

Mr. ASHMORE. Mr. Hutchinson.

Mr. HUTCHINSON. I have no questions, Mr. Chairman.

Mr. ASHMORE. Mr. McClory.

Mr. MCCLORY. I, also, join in the complimentary remarks concerning Senator Javits. I would like to ask a couple questions, if I may.

The first question I have is perhaps administrative in regard to this overall legislation. Congressman Celler has put his proposal in a comprehensive single bill which is before this committee, whereas I note your proposal is in several bills, and I think the same situation prevails in the House with regard to bills sponsored by Mr. Ogden Reid and others.

You feel, do you not, that what we are getting at is a comprehensive program which is bound up generally in the legislation sponsored by Congressman Celler?

Senator JAVITS. I think the omnibus bill approach is fine. I think the reason for the separate bills and the reason for the omnibus bill are very understandable in practical terms. Congressman Celler is chairman of the whole Judiciary Committee. In the Senate, we had

two subjects properly the subject for the Judiciary Committee, and two properly the subject for the Labor and Public Welfare Committee. The people in the Senate proposing them did not have the relationship to one committee which Congressman Celler enjoys. Hence we felt we would take care of the jurisdiction ourselves, knowing it would have to go to two committees, instead of putting it in the air as to which committee it would go to. But the omnibus approach is entirely satisfactory.

Mr. McCLORY. You feel it should all be part of a package?

Senator JAVITS. I do, even the medical treatment aspects. The reason is we are presenting a new philosophy, a comprehensive new program, to the country.

Mr. McCLORY. And it would be unfortunate if the treatment program went through as recommended by the administration without the grant program?

Senator JAVITS. Yes. It would be unfortunate to set up these new procedures without providing tangible support to back them up. You are exactly right.

Mr. McCLORY. There are various agencies that are involved in this, and various public officials would be involved in this program which you are recommending—the Attorney General, the Surgeon General, the U.S. district attorney, the Department of Health, Education, and Welfare, and perhaps one or two others. Whom do you envision as the overall administrator or authority in this program?

Senator JAVITS. I think you do have at least two departments with coordinate responsibilities, perhaps three if you take in the flow of narcotics as well—Treasury, HEW, and the Attorney General. There are many programs that are in the same position. Sometimes there is an interagency committee. I would not wish to advance my judgment as against that of the executive department as to who should be the head man. I think that should be left to the President and the Bureau of the Budget. If what they decided in my judgment were objectionable, I would protest and try to get it changed, but I think it would be a mistake in the first instance to substitute my judgment for that of the executive department as to who would handle the whole job when a number of departments are necessarily involved. For example, we could not say that the Attorney General for this purpose should handle the rehabilitative work; it would not work. So I think we have to leave that to the executive in the first instance.

Mr. McCLORY. I notice application for treatment may be made alternatively to the Attorney General or to the Surgeon General. Do you have an opinion as to whether the Attorney General or the Surgeon General should be the one to make the decision?

Senator JAVITS. In court proceedings the judgment will be that of the court with the recommendation of the prosecuting attorney and of the Surgeon General, so I think that is fairly tight. I think the fundamental judgment will come from the court but with the advice—and in the case of the prosecuting attorney more than advice, the participation—of other agencies of the Government.

Mr. McCLORY. I notice the Celler bill and your comprehensive legislation is patterned after that of the State of New York more than any other, and I know the experience in New York has not been very extensive yet, however I note the State of New York has the sharpest

increase in active narcotics cases and also the greatest increase in new cases. New cases are up by one-third and the overall number of cases is up by almost 20 percent. I just wonder whether that affects your judgment as to the efficacy of the New York program?

Senator JAVITS. I think the question is how high it would be if they had not gotten started on what they are doing. The incidence of long hot summers and so forth in New York is such that New York would be in a crisis if the legislation had not moved when it did.

I would rather turn to the situation in California, which preceded New York in the passage of legislation, and where very material improvement has been made, as validating the approach. We are not just dreaming this up ourselves. It seems to be very clear the program has resulted in some improvement. So I feel we are not venturing blindly in this field.

Mr. MCCLORY. We want to make up our minds on the basis that it works and not on a theory.

Senator JAVITS. Absolutely.

Mr. MCCLORY. As Senator Kennedy pointed out, in regard to the persons alluded to in his testimony, it appears the New York program is not efficacious in the same way the California experience is because of the lack of adequate aftercare in New York. I wonder whether you agree with that?

Senator JAVITS. I do not agree. I do not think New York should be penalized for the problems inherent in starting a program; it should be given the credit for starting it. I do not think that should obscure our judgment on New York. New York joined with California, albeit 2 years later, to pioneer in a program that takes some time to get underway. I think we would be in a runaway situation in New York if we had not done anything. When I was attorney general in 1955 and 1956 I was preparing for an early start, but these things do not move as fast as we would like them to. After all, who are we in the Federal Government, who for all these years have been treading a path that has not made any progress, to complain of the actions of a State that is trying? I think we have to take into account that New York has started a forward-looking program and showing good faith by appropriating a substantial amount of money. There is every promise of greater ability to control the problem in New York with these facilities than there would have been without them.

One other thing about the New York situation that is a problem: Under the laws of New York one of the narcotics crimes, possessing a small amount of heroin, less than one-eighth of an ounce is a misdemeanor. And the dockets have been so clogged that addicts who are charged with a felony have been getting by because the courts have been forced by overcrowded dockets to accept a plea of guilty to a misdemeanor. Since the maximum penalty for a misdemeanor is 3 months' imprisonment, relatively few defendants have chosen civil commitment, which can mean confinement for treatment for up to 3 years. With the facilities for treatment we can now do something with these people and, if they were held for the felony charge, I think you would find a dramatic turnaround in New York.

Mr. MCCLORY. In Illinois our progress has been the result of tightening up and I would not want this type of program to relax in any way the severity of penalties with regard to serious offenders. I am sure you agree with that.

Senator JAVITS. Yes, of course, I heard Senator Kennedy respond to that, and I agree.

Mr. MCCLORY. I think you recommend in your bill a 36-month period of commitment and a 2-year period of aftercare?

Senator JAVITS. Yes.

Mr. MCCLORY. Do you regard that as adequate in view of your experience with this matter?

Senator JAVITS. I would say not only from my experience but from the best experience we can draw upon. They seem to be the optimum figures, and they are very similar to those in California, where there is a 30-month commitment period and a 3-year aftercare period. There is some flexibility in those figures, but they seem to be the optimum so far as the experts can judge.

Mr. MCCLORY. Thank you.

Mr. ASHMORE. Senator, the California law provides, as I understand it, that those people declared eligible for civil commitment, before they receive commitment must first plead guilty to whatever the charge might be; whereas the Celler bill and the administration bill, and perhaps the law in New York, do not provide that he must first plead guilty but he can voluntarily agree to commitment.

Senator JAVITS. I am sure the committee will have testimony on that score from experts. We think chances for rehabilitation are greater where you do not require the patient first to plead guilty. California has pretrial proceedings where the patient knows what will happen to him if he is convicted and that a guilty plea will not lead to a jail sentence but to rehabilitation.

We incorporated the pretrail approach because we feel it represents the preponderance of expert views, that is, that commitment is more likely to result in rehabilitation if it precedes the conviction.

Mr. ASHMORE. The California law also provides for expunging the record if the person proves to be rehabilitated.

Senator JAVITS. I am giving the committee the benefit of the prevailing expert opinion, which we accepted.

Mr. ASHMORE. Many addicts would jump to the opportunity to take the civil commitment.

Senator JAVITS. There are two points to be made there. Our bill includes both preconviction and postconviction treatment. And secondly, a patient must be found acceptable by the medical authorities. I agree with you many would jump at it, but they must be found acceptable by the medical authorities.

Mr. HUNGATE. Under the provisions whereby they are not required to plead guilty in order to qualify under the act, as I understand it, if they respond satisfactorily to treatment the criminal proceedings cannot be further prosecuted.

Senator JAVITS. Criminal proceedings would be suspended, but the defendant may be remanded to the court if rehabilitation is not successful and he can then be tried in court.

Mr. HUNGATE. I am taking a case in which he successfully responds to treatment.

Senator JAVITS. If he successfully responds to treatment, that is the end of the matter.

Mr. HUNGATE. And another narcotic addict, on a charge relating to crime, or one who is not an addict, would have to plead guilty to obtain probation?

Senator JAVITS. Exactly.

Mr. HUNGATE. If he responded satisfactorily and was rehabilitated he still would have a criminal record?

Senator JAVITS. Exactly.

Mr. ASHMORE. I have a request by counsel to ask a question.

Mr. SHATTUCK. On the question of facilities, the testimony on behalf of the Public Health Service yesterday referred to it, and Dr. Terry stated:

> Since drug abuse is basically related to mental health problems we believe that assistance to the States in dealing with drug abuse should be accomplished within the framework of Federal aid to community mental health services rather than through a separate program.

He went on to state they felt the machinery under the mental health aspect of Federal aid would accomplish the same purposes. Do you have any comments?

Senator JAVITS. Yes. I think you will find, if you will examine what is being done in the mental health program, as an actual matter there will not be sufficient aid for treatment facilities for addicts. In other words, whatever they are doing under that program does not accomplish anything really substantial for this purpose. I have myself testified to the possibility of aid through community mental health centers because I inserted that provision in the conference report on the 1963 Mental Health Centers Construction Act. But you will see from their request for appropriations that it actually is not happening. I don't care where the narcotic facilities get the appropriation. As far as I am concerned, it is fine with me if it is authorized by the Mental Health Centers Act and they come in and ask for it under that act. The fact is, however, that they do need a separate mandate to ask for it for this purpose, because, if it is incorporated within the concept of the mental health centers as they stand now, notwithstanding that the Surgeon General is right about the fact that he has referred to, it will be lost in the crowd.

Mr. SHATTUCK. Thank you, Senator.

Mr. ASHMORE. Thank you very much.

Senator JAVITS. Thank you very much.

STATEMENT OF HON. SEYMOUR HALPERN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. HALPERN. Mr. Chairman, I believe there has been an oversight, and I believe this subject is of such importance that I, for one, could not overlook it.

Mr. ASHMORE. I do not understand; please tell us what you have in mind.

Mr. HALPERN. I stated, Mr. Chairman, that I believe there has been an inadvertent oversight, and, since the scope of this subject is of such vital importance, I could not overlook the oversight. Hence, having read of these hearings, having been of no other knowledge of them, I am taking the liberty of appearing here this morning.

There are bills mentioned as having been introduced on this subject on which these hearings are being held. I would like to point out that on the opening days of this session I introduced several bills dealing with this subject, including a broad civil commitment bill.

The bill is consistent with legislation that I have introduced for many years, Mr. Chairman. May I refer, for the record, to H.R. 2979, which was referred to the Judiciary Committee. It is a broad bill on this same subject, not too far removed from the bill introduced by the chairman of the full committee, from the administration bill, or the bill introduced by Senator Javits and Kennedy.

Mr. ASHMORE. I am sure it was inadvertent.

Mr. HALPERN. That is why I did say it was inadvertent.

Besides H.R. 2979, I also introduced H.R. 3033 on January 18, which is a supplemental piece of legislation to 2979.

Mr. ASHMORE. Without objection, H.R. 2979 and H.R. 3033 will be made a part of the record at this point.

(H.R. 2979 and H.R. 3033 follow:)

[H.R. 2979, 89th Cong., 1st sess.]

A BILL To enable the courts more effectively to deal with the problem of narcotic addiction

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

DECLARATION OF POLICY

SECTION 1. It is the policy of the Congress that, in the administration and enforcement of Federal penal laws dealing with narcotics, individuals whose violation of any such law is attributable to the fact that they are victims of narcotic addiction should be afforded an opportunity for treatment and rehabilitation, and individuals whose violation of such laws is not so attributable should be dealt with as criminals deserving of severe punishment.

DEFINITIONS

SEC. 2. For purposes of this Act—

(a) The term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended;

(b) The term "drug user" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction;

(c) The term "Surgeon General" means the Surgeon General of the Public Health Service.

PROCEEDINGS BEFORE COURT

SEC. 3. (a) Any eligible person charged with a violation of a Federal penal law relating to narcotics, other than the sale or other transfer of narcotics, shall, upon being brought before a committing magistrate, be informed that the prosecution of the criminal charge will be held in abeyance if the eligible person chooses to submit to an immediate examination to determine if he is a drug user. He shall be further informed that if he makes such an election and it is found that he is a drug user, and the court so orders, he shall then have to submit to a mandatory civil commitment. At the request of the eligible person, or on the order of the court, he may be permitted a maximum of five days subsequent to his being brought before a committing magistrate in which to make this election and he shall be informed of his right to such a delay. In the absence of such timely election, except upon a showing of substantial reasons why the election could not timely be made, the eligible person will be barred from such an election after the prescribed period; or, if he chooses not to so elect, he will be barred from doing so thereafter. If the eligible persons elects consideration for civil commitment, he shall remain under the custody of the United States marshal or be placed under the custody of the Surgeon General, as the court may direct, for the purposes of an appropriate medical examination, for a period not exceeding ten days.

(b) Within such ten-day period the Surgeon General shall transmit to the court a certified report as to whether the eligible person is a drug user and

the eligible person shall be returned to the court for such further proceedings as may be necessary. A copy of the report shall be made available to the eligible person and to the Government attorney. If the eligible person wishes to contest the findings contained in the report, the court shall order a hearing. At such hearing the court may, besides considering the content of the report, consider any other relevant information which may be brought to its attention. If the court, acting on the report and on the hearing if any, holds that the eligible person is not a drug user, he shall be held to answer the criminal charges which were previously held in abeyance. If the court, acting on the report and on the hearing if any, determines that the eligible person is a drug user, the eligible person may be committed to the custody of the Surgeon General.

(c) No person charged with a violation of a Federal law relating to narcotics shall be eligible for civil commitment if it appeared that—

(1) the offense involved the sale or transfer of narcotics;

(2) there is pending against the person a prior charge of a crime and such charge has not been finally determined or sentence following conviction on such charge, including any time on parole, has not been fully served;

(3) the person has been convicted on one or more prior occasions of a felony;

(4) the person has previously been civilly committed because of his narcotics use;

(5) facilities for the hospital care and treatment of narcotic users, or facilities for their aftercare supervision, are certified by the Surgeon General to be unavailable or inadequate at the time the commitment is sought;

(6) it is not in the interest of justice to commit the person civilly.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charge which led to his arrest shall be continued without final disposition and shall be dismissed only after the drug user has been released from the custody of the Surgeon General and has been duly certified by the aftercare authority as having successfully completed the aftercare period. If the Surgeon General at any time prior to such certification determines that the drug user cannot be further treated as a medical problem because of his apparent incorrigibility or nonresponsiveness to medical treatment, he shall so advise the court and the criminal proceedings against the drug user shall thereupon be resumed. In the event criminal proceedings are resumed, after having been held in abeyance, the drug user shall receive full credit, against any sentence which may be imposed, for the time spent in the custody of the Surgeon General.

(e) There shall be no adjournments between arrest and civil commitment other than for the five-day period specified in subsection (a) of this section, except for compelling reasons, and a person who requests consideration for civil commitment shall not be admitted to bail or parole or released on his own recognizance during the pendency of the examination and commitment procedures.

COMMITMENT OF DRUG USER

SEC. 4. (a) A drug user committed to the custody of the Surgeon General under the provisions of this Act shall be committed for an indeterminate period not to exceed five years. The drug user shall not be released prior to the expiration of this five-year period unless it is certified by the Surgeon General that the drug user has been effectively removed from the habitual use of drugs.

(b) Upon release from such an indeterminate commitment the former drug user may be required to report periodically for a period of not more than two years for such probationary aftercare treatment as the Surgeon General may direct, the purpose of such probation being to insure that the former drug user does not return to the use of drugs. Throughout this period the probationer shall also be subject to home visits and to such reasonable regulation of his conduct as the probationary aftercare authority may establish.

(c) Throughout the probationary period such probationer shall submit to such reasonable tests to detect the use of narcotics as may be ordered by the probation authorities. If it is established at a hearing held by the probationary aftercare authority, or it is established by the probationer's own written statement, that he has returned to the use of narcotics, the Surgeon General shall so advise the court and the criminal proceedings against the drug user shall thereupon be resumed.

CIVIL COMMITMENT NOT TO BE A CONVICTION

SEC. 5. The determination made by the court, on the report of the Surgeon General, that any person is a drug user within the meaning of this Act, shall not be deemed a criminal conviction, nor shall such person be denominated a criminal by reason of such determination. The results of any tests or procedures to determine narcotic addiction by the Surgeon General shall not be used against the examined person in any criminal proceeding. The results may only be used in a further proceeding under this Act, such a proceeding not to include any criminal charge continued without final disposition under this Act. The fact, however, that a person is a drug user may be elicited on his cross-examination as bearing on his credibility.

USE OF STATE FACILITIES

SEC. 6. The Surgeon General is authorized to enter into agreements with States (and political subdivisions thereof) under which appropriate facilities of such States, or political subdivisions thereof, as the case may be, will be made available, on a reimbursable basis, for the care of individuals civilly committed pursuant to the foregoing provisions of this Act.

PENALTIES FOR POSSESSION OF NARCOTIC DRUGS AND MARIHUANA

SEC. 7. (a) Section 4704(a) of the Internal Revenue Code of 1954 (relating to transfers of narcotic drugs not in a stamped package) is amended by adding at the end thereof the following new sentence: "Whoever purchases a narcotic drug in violation of this subsection with the intent to consume all of such drug shall be imprisoned not more than 5 years, or fined not more than $5,000, or both."

(b) Section 4744(a) of the Internal Revenue Code of 1954 (relating to unlawful possession of marihuana) is amended by adding at the end thereof the following new sentence: "Whoever acquires or otherwise obtains marihuana in violation of this subsection, or transports, conceals, or in any manner facilitates the transportation or concealment of marihuana so acquired or obtained, with the intent to consume, or otherwise administer to himself, all of such marihuana, shall be imprisoned not more than 5 years, or fined not more than $5,000, or both."

STATE LAWS NOT AFFECTED

SEC. 8. This Act shall not be construed as indicating an intent on the part of Congress to occupy the field in which this Act operates to the exclusion of a law of any State, territory, Commonwealth, or possession of the United States, and no law of any State, territory, Commonwealth, or possession of the United States, which would be valid in the absence of this Act shall be declared invalid, and no local authorities shall be deprived of any jurisdiction over any offense over which they would have jurisdiction in the absence of this Act.

SEPARABILITY PROVISION

SEC. 9. If any provision of this Act or the application of such provision to any circumstance shall be held invalid, the validity of the remainder of this Act and the applicability of such provision to other circumstances shall not be affected thereby.

EFFECTIVE DATE

SEC. 10. (a) Except as provided in subsection (b), this Act shall become effective on July 1, 1965, and shall not apply to any case pending in any court of the United States arising from an arrest made prior to July 1, 1965.

(b) The amendment made by section 7 of this Act shall apply only with respect to violation of section 4704(a) and section 4744(a) of the Internal Revenue Code of 1954 which are committed after July 1, 1965.

[H.R. 8033, 89th Cong., 1st sess.]

A BILL To permit wiretapping by an authorized Federal officer engaged in the investigation of illegal importation of narcotic drugs into the United States

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Narcotic Interception Act".

SEC. 2. A Federal investigative or law enforcement officer of an executive department of the Federal Government, which has been authorized to intercept a wire communication by an ex parte order issued by a Federal judge under section 5 of this Act, may intercept such a communication to obtain evidence of a violation of section 2(c) of the Narcotic Drugs Import and Export Act (relating to the illegal importation of narcotic drugs in the United States) and may utilize the information contained in such communication only in accordance with section 6 of this Act.

SEC. 3. (a) The head of any executive department of the Federal Government having investigative responsibility for violations of section 2(c) of the Narcotic Drugs Import and Export Act may make an application to a Federal judge for an ex parte order to permit the interception of a wire communication. Such an application must contain the information specified in section 4 of this Act and must be authorized by the Attorney General, Deputy Attorney General, or an Assistant Attorney General of the Department of Justice, specially designated by the Attorney General.

(b) Whenever the Attorney General, Deputy Attorney General, or an Assistant Attorney General of the Department of Justice, specially designated by the Attorney General, determines, on the basis of the information supplied to him by head of such an executive department, that a specified wire communication's interception may obtain evidence of such a violation, he may authorize an application to a Federal judge for an ex parte order permitting such specified interception.

SEC. 4 (a) Each application to a Federal judge for an ex parte order shall contain the following information:

(1) A full and complete statement of the facts and circumstances relied upon by applicant;

(2) The nature and location of the communication facilities involved; and

(3) All previous applications, known to the individual authorizing the application, made to any judge for leave to intercept wire communications involving the same communication facilities, or any of them, or involving any person named in the application as committing, having committed, or being about to commit the offense described in section 2(c) of the Narcotic Drugs Import and Export Act, and the action taken by the judge on each such application.

(b) The judge may require the applicant to furnish additional testimony or documentary evidence in support of the application.

SEC. 5. (a) Upon such application the judge may enter an ex parte order granting leave to intercept wire communications at any place within the territorial jurisdiction of the court in which the judge is sitting, if the judge determines on the basis of the facts submitted by the applicant that there is probable cause for belief that—

(1) the offense for which such an application may be filed under this Act is being, has been, or is about to be committed;

(2) the facts concerning that offense may be obtained through such interception;

(3) no other means are readily available for obtaining that information; and

(4) the facilities from which communications are to be intercepted are being used in connection with the commission of such offense, or are leased to, listed in the name of, or commonly used by, a person who has committed, is committing, or is about to commit such offense.

(b) Each order granting leave to intercept any wire communication shall specify—

(1) the nature and location of the communications facilities as to which leave to intercept is granted;

(2) the offense as to which information is to be sought;

(3) the identity of the Federal executive department authorized to intercept the communications; and

(4) the period of time during which such interception is authorized.

(c) No order entered under this section may grant leave to intercept any wire communication for any period exceeding forty-five days. Extensions of the order may be granted for periods of not more than twenty days each upon further application made in conformity with sections 3 and 4 of this Act and upon the findings required by this section.

SEC. 6. (a) Any investigative or law enforcement officer, who has obtained knowledge of the contents of any wire communication in accordance with this Act, may—

(1) disclose such contents to another investigative or law enforcement officer to the extent that such disclosure is appropriate to the proper performance of the official duties of the officers making and receiving the disclosure, and

(2) use any information therein contained in the proper discharge of his official duties, and

(3) disclose the contents of that communication while giving testimony under oath or affirmation in any criminal proceeding in any court of the United States or in any Federal grand jury proceeding.

(b)(1) The contents of an intercepted wire communication shall not be received in evidence or otherwise disclosed in any criminal proceeding in a Federal court unless each defendant, not less than ten days before the trial, has been furnished with a copy of the court order or other authorization pursuant to which the interception was made. The ten-day period specified above may be waived by the judge if he finds that it was not possible to furnish the defendant with the above information ten days before the trial, and that the defendant will not be prejudiced by the delay in receiving such information.

(2) Any defendant in a trial in a Federal court for violation of section 2(c) of the Narcotic Drugs Import and Export Act may move in that court to suppress the use as evidence of the contents of any intercepted communication or any part thereof or evidence derived therefrom, on the ground that (A) the communication was unlawfully intercepted; (B) the order pursuant to which it was intercepted is insufficient on its face; (C) there was not probable cause for believing the existence of the grounds on which the order was issued; or (D) the interception was not made in conformity with the order. Such motion shall be made before trial or hearing unless opportunity therefor did not exist or the defendant was not aware of the grounds of the motion, but the court in its discretion may entertain the motion at the trial or hearing. If the motion is granted the evidence shall not be admissible in any court or proceeding.

(c) Applications made to a court and orders granted by the court pursuant to this Act shall be sealed by the court. They shall not be made public except in accordance with this Act or by order of the court.

SEC. 7. (a) Within thirty days after the expiration of any order (including any extension thereof) entered by any Federal judge under this Act, the judge shall cause to be transmitted to the Administrative Office of the United States Courts and to the Attorney General of the United States a true and correct copy of (1) that order and any order for the extension thereof, and (2) the application or applications made therefor. Within thirty days after the denial by any judge of any application made to him for the entry of any order, or for the extension of any order previously entered by him, under this Act, the judge shall transmit to the Administrative Office of the United States Courts and to the Attorney General of the United States a true and correct copy of that application.

(b) In March of each year the Director of the Administrative Office of the United States Courts shall transmit to the Congress a full and complete report concerning the number of applications which were made, granted, and denied during the preceding calendar year. Such reports shall state—

(1) the number of applications made by or on behalf of each Federal executive department, and the number of orders granting or denying such applications; and

(2) the number of applications made to, and granted and denied by, each Federal court.

SEC. 8. As used in this Act—

(1) The term "wire communication" means any communication made through the use of facilities for the transmission of communications by the aid of wire, cable, or other like connection between the point of origin and the point of reception, furnished or operated by any person engaged as a common carrier in providing or operating such facilities for the transmission of interstate or foreign communications;

(2) The term "interstate communication" means any communication transmitted (a) from any State to any other State, or (b) within the District of Columbia or any possession of the United States;

(3) The term "foreign communication" means any communication transmitted between the United States and any foreign country;

(4) The term "State" means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and any possession of the United States;

(5) The term "intercept" means the acquisition of the contents of any wire communication from a wire communication facility or component thereof, through the use of any intercepting device, by any person other than the sender or receiver of such communication or a person authorized by either;

(6) The term "intercepting device" means any device or apparatus, other than an extension telephone instrument furnished to the subscriber or user by a communication common carrier in the ordinary course of its business as such carrier;

(7) The term "contents", when used with respect to any wire communication, includes any information concerning the identity of the parties to such communication or the existence, contents, substance, purport, or meaning of that communication;

(8) The term "Federal investigative or law enforcement officer" means any officer of the United States who is empowered by law to conduct investigations of or to make arrests for violations of section 2(c) of the Narcotic Drugs Import and Export Act and any attorney authorized by law to prosecute or participate in the prosecution of such violations; and

(9) The term "Federal judge" means a judge of a United States district court or a United States court of appeals.

SEC. 9. The proviso at the end of section 605 of the Communications Act of 1934 (47 U.S.C. 605) is amended to read as follows: "*Provided*, That this section shall not apply to (a) the intercepting, receiving, divulging, publishing, or utilizing the contents of any radio communication broadcast or transmitted by amateurs or others for the use of the general public, or relating to ships in distress, or (b) the interception of any wire communication, or the divulgence or disclosure of the existence, contents, substance, purport, or meaning thereof, if such interception, divulgence, or disclosure is authorized by the Federal Narcotic Interception Act."

SEC. 10. If any provision of this Act or the application thereof to any person or circumstance is held invalid, the other provisions of this Act and the application of any provision to other persons or circumstances shall not be affected thereby.

Mr. HALPERN. I also introduced two other bills on this subject which were referred to other committees. But the civil commitment aspect is covered in H.R. 2979. It is similar to legislation I introduced in the 88th Congress and in the 87th Congress.

I might say that, as one of the sponsors of the legislation that brought about the White House Conference on Narcotic and Drug Abuse, and one who followed that conference very closely, and one who introduced seven bills following its recommendations when they made their report to the President, I am intensely interested in this subject, Mr. Chairman, and I would be remiss if I did not seek this opportunity for a few words. I do realize the hour is late. If I may, if you do intend to have further hearings, I will be happy to appear at that time, or if you wish, I will continue at this time.

Mr. ASHMORE. We will try to finish now, if you will.

Mr. HALPERN. All right, Mr. Chairman.

I should also add that this subject is not only of particular legislative interest to me because of the background I just mentioned, but I do think, for the record, I should elaborate a bit more on this background, because I have been especially close to the subject of narcotics addiction. I was a New York State senator——

Mr. ASHMORE. That is a quorum call, and we will recess until 2:30.

(At 12:20 p.m., the subcommittee recessed, to reconvene at 2:30 p.m. the same day.)

AFTERNOON SESSION

Mr. ASHMORE. The committee will be in order.

At lunchtime, Mr. Halpern, the staff searched the record to find what it was that went wrong and why your bills, H.R. 2979 and H.R.

3033, which you introduced both on January 18, 1965, were not listed here, and they had not been referred to our subcommittee.

Mr. HALPERN. The title of the bill does indicate they were referred to the Judiciary Committee.

Mr. ASHMORE. I understand that, sir, but they had not been referred to our subcommittee.

Mr. HALPERN. Is not that obviously an inadvertent error on the part of the full committee, whoever handles the reference?

Mr. ASHMORE. I do not know where the error came, but we had not received them.

Mr. HALPERN. I am glad they have come to the attention of the committee at this point, anyhow.

Mr. ASHMORE. You may proceed.

Mr. HALPERN. I appear today, as I mentioned earlier, as sponsor of H.R. 2979, which deals with civil commitments of narcotic addicts. This bill follows a proposal I have long advocated. In fact, for many years I have introduced legislation of this type, and it was again introduced at this session. In fact, it was the first bill of its kind, having been introduced on January 18, as the chairman mentioned, before the similar legislation referred to at these hearings.

For the purpose of further background—I believe this is important—I want to point to a program that I sponsored as a New York senator. I served, Mr. Chairman, in the New York Senate for 14 years, and it was one of my specialized subjects in that capacity. Following an intensive probe, which I initiated under the State attorney general, I sponsored several State laws bringing New York's laws to where they should have been at that time. Of course, this goes back 10 years ago and a lot more has been accomplished since, but these bills included new laws to require the teaching of students in schools about the evils of narcotics, to outlaw hypodermic needles without a prescription by doctors. We reduced the quantity of narcotics needed to determine possession with intent to sell. Heretofore you could have huge quantities and it would be just a misdemeanor and we brought the quantity down to an eighth of an ounce. We included marihuana within the category—not in the technical sense or in the chemical sense—of a narcotics drug and we brought them within the narcotic laws in the same category as the narcotic drugs. We provided tougher penalties for offenders. And this is important because of the nature of the legislation before you. We also allowed—and this goes back 10 years ago—civil commitment for minors; that is, preadult addiction, under 21 years of age, to youngsters if addicted to narcotics. That law—and I think it has a bearing—required the commitment of these users under the department of hospitals.

In other words, the youngster who was apprehended or was brought by the school official, or a parent, or maybe even voluntarily came in, whether he was an offender of some type of just a drug found in his possession, would be committed by a judge over to the hospital department, sent to a hospital, and for a period of 3 years he would be under the jurisdiction of that department and the director of this program. If he failed to cooperate, if he didn't follow up in the aftercare aspects of this, if he didn't attend the clinic, and didn't adhere to the program prescribed, he could then, and then alone, be picked up as a wayward minor. Of course, we are dealing here only with youngsters under 21

years of age. As I mentioned, the total period of treatment could be up to 3 years, and then, if the patient failed to follow through with the program, he would then be picked up as a wayward minor. I feel this was a splendid program. It was the only help, as I could see it, for these young addicts.

New York City, in order to implement these programs, opened Riverside Hospital for these young addicts. And I might say, Mr. Chairman, I was named chairman of the board of the hospital and have served in that capacity since.

I saw firsthand, Mr. Chairman, not hundreds of addicts, but literally thousands. We must have had 4,000 youngsters pass through the hospital, 13-, 14-, 15-year-old addicts, mainliners, on heroin, the worst type of addicts.

Mr. ASHMORE. What drug did they use?

Mr. HALPERN. Ninety-five percent were on heroin. All started with the so-called goofballs, pep pills, that you have heard so much about this session, and graduated to marihuana first, and then skin popping, and then sniffing, and then finally heroin, the mainline.

Mr. KING. Mr. Halpern, don't you believe under those circumstances we should not be too soft on these marihuana users?

Mr. HALPERN. Of course we should not be soft on the marihuana users.

Mr. KING. Testimony indicated today that we should, as I understood it, more or less put marihuana in a different class.

Mr. HALPERN. I wouldn't. In New York State—and I mentioned that earlier—we included in our laws the possession of marihuana. We could not use the same quantity; that is, the weight factor. In New York, at least while I was there, the possession of 25 cigarettes or the equivalent in the marihuana weed of 25 cigarettes would be sufficient in order to be presumption for the intent to sell. This is in New York State law. They have included marihuana. As I said, technically or legalistically or chemically you cannot necessarily call it a narcotic drug as such, but to me it is habit forming. Anything can be habit forming, and it is the first step. I know of few exceptions.

I had tape recordings of hundreds of these addicts and how they got started and their histories, and it all follows a pattern, and marihuana is in that pattern, very much so, Mr. Chairman. And this comes firsthand.

New York City, Mr. Chairman—and I say this with full knowledge—New York City failed, failed miserably to implement these laws properly. No clinics were set up for the so-called aftercare for checkups on these youngsters. Sure, we cured them in the hospital. That is not too difficult—2 months, 3 months, sometimes 6 months. We had schools there, we had vocational training there, we had good professional help. But then they went outside and in case after case they regressed right back to the same pattern.

And why? Because the city did not implement the program. The intention was good, the program was good, but they didn't set up the aftercare clinics, they didn't have proper personnel to follow up with the individuals, and the excuse given for this failure was the claim that there was, one, no funds, no cooperation, no personnel, no interest on the part of the public, and that is why it failed.

Mr. Chairman, it is so vital that we focus our attention on this problem and enact legislation to implement and supplement State and local efforts. I think this is vital.

Imagine, if any other cause could be given for hundreds of deaths a year—and there are hundreds of deaths among youngsters alone as a result of narcotic overdoses—Dr. Baird, Robert Baird, who is somewhat of an authority on this subject in New York—and I hope he has an opportunity to appear before your committee. He has a clinic in New York and has done a remarkable job. He tells me that is his estimate, and this is based on conferences with hospital officials and otherwise, and it is not always listed as such, but there are at least 500 deaths a year in New York City alone caused by overdoses of narcotics. If this were an epidemic or other destroyer of life, then the city and the public throughout the Nation would be aroused, and you can rest assured there would be needed action. To me narcotic addiction is the scourge, and it is incumbent upon us to do something about it, Mr. Chairman.

With that, I have testimony I would like to talk about on the bill. If you want me to come back I will be glad to.

Mr. ASHMORE. We will return as soon as we can answer the quorum call.

(Short recess.)

Mr. ASHMORE. You may proceed, Mr. Halpern.

Mr. HALPERN. Thank you, Mr. Chairman, for giving me the opportunity to resume where we left off when the quorum bells rang and testify on behalf of narcotics legislation that I introduced in January of this year to which I referred earlier.

This legislation follows similar measures I have advocated for many years. Inasmuch as my bills this year are quite similar to those recently introduced by my colleagues from New York, Senators Javits and Kennedy, who have already testified and, in principle, not too far removed from the legislation of the distinguished chairman of your full committee, I shall be quite brief this afternoon.

We all realize the gravity of the narcotics problem, and I believe that the legislation now before this distinguished committee represents an enlightening effort on the part of this Congress to meet and solve this problem.

If we are to solve this problem, we must do three things.

We must stop the illegal flow of narcotics into this country.

We must study the medical and psychological aspects of addiction.

We must help those who have become addicted to break this habit.

Since the 1963 report of the President's Advisory Committee on Narcotics and Drug Abuse, the Federal Government has all but ignored many serious new proposals designed to carry out the recommendation of the committee designed to combat the disease of drug addiction. Narcotics addiction is indeed a disease and must be recognized as such. In the case of the addict, this country has not yet emerged from the anachronistic practice of treating an illness as a crime.

Dependence on drugs can twist a person's mind; it can lead him to steal and even to kill in order to get a supply of drugs. It does no good to punish a person or theft if nothing is done to relieve the motivating cause of theft—in this case, the physical dependence on drugs. Addiction cannot be used as a license to steal, but an addict who does

steal in order to support his habit should not be treated as an ordinary criminal. Our legal system provides special care for mentally ill persons who have committed crimes, and similar provisions should be extended drug addicts, for addiction, too, is a disease.

Anyone who is closely connected with this area realizes that this is a disease, and, as a result, many State and private facilities have been established to treat these people.

Synanon, a private organization, has apparently been having some success, although I do not believe we have had ample time to adjudicate the total effectiveness of this approach. California has a State program, as do New York and New Jersey, and it is becoming increasingly well recognized that treatment is better than simple incarceration.

The Federal Government, originally a leader in the fight against addiction, is now lagging far behind in these efforts. And this is a field in which the Federal Government should assert its leadership role. Because of the Federal responsibility to control the illegal importation of narcotics and to deal with violators of Federal law who are also addicts, Congress should provide for the treatment of addicts, and do all it can to further research.

In the field of treatment and facilities, this country had, in the 1920's, a number of clinics for the ambulatory treatment of addicts. In 1935 the Federal Government, under the auspices of the U.S. Public Health Service, established a hospital for treating addicts in Lexington, Ky., and 3 years later a similar institution was established in Fort Worth, Tex.

For the next 15 years, no additional facilities were added. There were a few private hospitals which offered minor services of short duration, and which were able to treat a patient over the acute episode of withdrawal. However, the total rehabilitation program received scant attention except for the two Federal instiutions mentioned.

Now, the limitations of these facilities are painfully clear. The typical patient at the Federal hospital in Lexington, which has a 1,000-bed capacity, is a male from the Northeast, who has left his family to travel hundreds of miles to Kentucky in the desperate hope of being cured. Nevertheless, the average patient there undergoes three to four cures. Authorities cannot force him to remain the 3 to 4 months generally required, but regardless, once he is back home, exposed to family tensions and the pressures and temptations of his old environment, divorced from medical or psychological treatment, he usually resumes his drug habit shortly thereafter. Without any sort of aftercare program, how can anything else be expected?

Without a followup, the results of the treatment cannot be analyzed, and thus the treatment itself cannot be adequately checked. It is a violation of scientific principles to fail to check the results of any experiment, and it is especially serious in this situation when the same experiment is performed on each patient.

For this reason, I am very happy to see in the chairman's bill provision for the regulation of the aftercare program under the auspices of the Surgeon General. This provision, which is also in my bill, is designed to provide rules and regulations governing the frequency and nature of visits with aftercare officials, and would provide for the compilation of statistics on the effectiveness of various methods of treat-

ment. In addition, the Surgeon General could specify a sufficiently low ratio of parolees or outpatients to supervisory personnel to insure careful, individual treatment and observation.

On the brighter side, this year $3 million, the first sizable Federal funds, are going into research and postwithdrawal programs, and States such as California and New York have developed their own programs.

These then are some of the ramifications of the narcotics problem in the United States: shortage of treatment facilities, insufficient enforcement personnel, lack of uniformity in criminal laws, increase in narcotics traffic, and absence of an overall approach utilizing most efficiently the resources of all levels of our society.

I cannot overemphasize the urgency of taking action to combat the current situation, particularly when the greatest tragedy involved is that narcotics addiction is most prevalent in teenagers and young adults—people who are trying to find their proper places in society. And we are not helping them.

The problems, then, are complex, and they must be attacked. A necessary first step is to reduce the supply of narcotics. To this end, it is essential to increase the number of port investigators and criminal investigators of the Customs Bureau and to enlarge the squad of enforcement officers of the Bureau of Narcotics. Earlier this year, I submitted a bill which would accomplish this.

Another proposal I have made and urge again is the legalization of wiretapping by an authorized Federal officer engaged in the investigation of illegal importation of narcotic drugs, when no other means of gathering vital evidence is readily available. This would only be permissible when a Federal judge determines that available evidence gives probable cause for belief that a violation of the Narcotic Drugs Import and Export Act is about to take place. Such an order, issued by the judge, would, of course, have to limit strictly the specific communications facilities and the period of time during which interception is authorized.

Stop the supply, but do not stop the program here. The addict is not automatically cured by ending his supply of drugs; he needs treatment and, in some cases, vocational training. The addict must have the opportuntiy to undergo treatment and he must be encouraged to accept it. Because of this, I have proposed a civil commitment provision for addicts arrested for violating a Federal law relating to narcotics.

Senators Javits and Kennedy have proposed two very fine bills providing for civil commitment and for the sentencing to treatment of addicts convicted of any Federal offense. These provisions are clearly a part of any effective attack on addiction. A person impelled to commit a crime in order to support his addiction must be treated as the addict he is, or after his release he will again be disposed to violate the law.

I also share with the Senators from my State the belief that States must be encouraged to expand their treatment facilities, and by encourage, I mean more than authorize the Surgeon General and Attorney General "to give representatives of States and local subdivisions thereof the benefit of their experience," as the administration bill limits the meaning of the term. In all due respect to our Federal

officials, I suggest that the administration of the California program, for example, could benefit us by giving their advice.

Federal subsidies to help cover the cost of construction, treatment and research are needed. Senate bills 2115 and 2116 contain such provisions, as to the proposals I made earlier this year in H.R. 2980. As a result of such a program, addicts would be able to receive much more aid from their States.

It is, of course, necessary to supervise the administration of such a program, and the creation of an advisory committee is called for. Among the powers of such a committee would be the supervision of aftercare programs—a facet, as I mentioned earlier.

Just this morning, the President signed into law a measure to control stimulant and depressant drugs. This is an important first step and it shows the concern of this Congress, but it is only a first step. Much remains to be done.

In order to protect the health of the public, this Congress should make provisions to combat narcotics addiction. At the same time, we must not lose sight of the dangers in the abuse of other drugs. Medical science has made great advances; when properly used, the wonderful drugs which have been developed can save countless lives. But when these same drugs are abused, tragedy is the inevitable result.

Mr. Chairman, this Congress must not ignore the necessity to regulate drugs; this Congress must not relax its vigil; and this Congress must deal with the narcotics problem now. I salute this subcommittee for its important efforts.

Mr. ASHMORE. Congressman Ottinger.

STATEMENT OF HON. RICHARD L. OTTINGER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. OTTINGER. Thank you, Mr. Chairman.

Mr. ASHMORE. We will be glad to hear from you.

Mr. OTTINGER. Mr. Chairman, I am honored to appear before this distinguished subcommittee in support of H.R. 9159, the administration's narcotic addict rehabilitation bill, which I was privileged to introduce in the House. It is the same, I believe, as Mr. Celler's H.R. 9167. Mr. Chairman, I have a statement prepared which I would like permission to submit at this point for the record. With your permission, I will shorten my remarks to include the particular matters on the operation of the bill.

Mr. ASHMORE. We will be glad to have that done.

(Mr. Ottinger's statement follows:)

STATEMENT OF RICHARD L. OTTINGER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Congressman Richard L. Ottinger, Democrat, of New York, today called the administration's proposed Narcotic Addict Rehabilitation Act, which he introduced in the House, "the first really new legislative approach to our narcotics addiction problem since the Harrison Act of 1914." The bill was sponsored in the Senate by Senator Thomas J. Dodd, Democrat, of Connecticut.

Testifying before a House Judiciary Subcommittee today, Congressman Ottinger urged passage of the bill which would permit nonpusher addicts charged with minor Federal crimes to be committed for treatment and rehabilitation rather than sentenced to jail terms.

The Congressman explained that dope peddlers, persons charged with crimes of violence, and others who are not good prospects for rehabilitation would be ineligible. He called for stiffened penalties against dope peddlers.

Congressman Ottinger said that the administration's drug bill differs from legislation proposed by New York Senators Robert F. Kennedy and Jacob K. Javits primarily in that it does not remove mandatory minimum sentences for dope peddlers and does provide for aftercare supervision of rehabilitated addicts for a period of time after release from hospitalization. In addition, the administration bill covers all persons arrested for Federal crimes, while the Kennedy-Javits bill covers only persons arrested for narcotics violations.

The Congressman said that the two bills were similar in that "they seek to incorporate in our national law the recognition that addiction is an illness separate and distinct from the very serious crime of illegal traffic in narcotics."

Congressman Ottinger also urged legislation authorizing Federal funds for "more and more specialized aftercare facilities operated by the States in local communities with severe drug problems." He also called for research into programs that would take the profit, criminal element, and incentive to crime out of the illegal traffic in narcotics such as the so-called clinic plan or English system.

Mr. OTTINGER. This bill and the similar bills—H.R. 9051 and H.R. 8912—being considered by this subcommittee at this time represent the first really new legislative approach to our American narcotics addiction problem since the Harrison Act of 1914.

I have introduced all of these bills, as have Chairman Celler and Senators Robert F. Kennedy and Jacob K. Javits. While the bills show minor differences in method, they have one very important thing in common, and that is they seek to incorporate in our national law the recognition that addiction is an illness separate and distinct from the very serious crime of illegal traffic in narcotics. They would use the vast resources of the Federal Government to cure, rather than punish, the sick.

For many years our doctors and scientists have known that the addict was a helpless victim, not a willful criminal. But our laws have not recognized this fact. By arresting addicts, branding them publicly as criminals and throwing them into jails, we have undoubtedly contributed far more to the continuance and spread of addiction than to its cure. The lessons that are learned in our prisons are not calculated to make healthy citizens of sick people.

It is not impossible that the new understanding of the nature of addiction that is reflected in the bills now before this subcommittee will bring about a change in our penal philosophy as profound and as important as the recognition in the 19th century that the insane were sick and not morally evil. We have an opportunity now to take a step which is both humane and wise by enacting this legislation.

I and my staff have devoted considerable time to the study of the addiction problem as it affects the great metropolitan area of New York City. We have talked to the doctors, writers, officeholders, and Federal and local police officials who have been most concerned with the addiction problem. Also, we have talked to the addicts themselves. Based upon this personal experience and upon what we learned from the published reports of the numerous studies that have been made of the problem and of existing laws, we have come to recognize a number of unfortunate facts.

You may wonder, Mr. Chairman, why a Congressman from Westchester County, N.Y., is concerned with narcotics, but it is a terrifying fact that this is not just a slum problem. Narcotics addiction has spread to the suburbs. We have some 200 known addicts, mostly

young people, in the city of Yonkers outside of New York City and youths as far north as Peekskill have been arrested for narcotics addiction. In our villages some of the most affluent and best-educated children in the community have become involved in this terrible affliction.

Mr. ASHMORE. Is this largely with reference to marihuana, or cocaine, or what?

Mr. OTTINGER. They have been involved in the complete spectrum of drug addiction. What usually happens, as I understand from local police officials, is they start out on so-called pep pills and goofballs and airplane glue that they can sniff. They are looking for kicks. The psychological motivation for people who get involved in these activities is not completely known at this point, but one thing leads to another, and they get involved in more and more serious drugs as they go along and generally they end up on heroin.

Mr. ASHMORE. Is it mostly young people that start with this type of thing for kicks and try it as an experiment to see what the effect will be?

Mr. OTTINGER. Apparently almost exclusively with young people.

Mr. ASHMORE. Do you know whether the goofball, barbiturate type of drug is habit forming?

Mr. OTTINGER. I am told——

Mr. ASHMORE. Marihuana is not.

Mr. OTTINGER. Marihuana is not, I am told, but some of the sleeping pills are habit forming, and they say so on the prescription. I think some are and some are not, but I would not be qualified as an expert.

Mr. ASHMORE. Thank you.

Mr. OTTINGER. First and foremost of the things we have learned is that our approach to the problem of addiction over the past 50 years has failed miserably. Repressive measures against addicts simply haven't worked.

We have learned that mere withdrawal of the addict from narcotics is not a cure. A narcotics addict needs extensive treatment that will help him to overcome the deep psychological problems that caused him to seek relief through narcotics in the first place. Once withdrawn, the addict needs help to rehabilitate himself in the community and to find a place of worth and value. We know that he does not get these from prison.

We also learned that such crime as is attributable to the narcotics addict arises not from the use of drugs, but from the addict's frantic efforts to get money for the drugs he requires when deprived. To punish the criminal act without curing the cause is a gesture of supreme futility. We return the addict to the streets as sick as he was when arrested in the first place—and perhaps more hardened and skilled at the criminal acts. The absurdity and cruelty of this "solution" has long been apparent to those who are knowledgeable in the problems of addicts.

New York police have estimated that on the average an addict must steal more than $1,000 per week to yield the money that he needs for drugs. He must steal so much, because these goods have to be passed down through a "fence," and his return is considerably less than the value of the goods. In terms of cold hard cash, this means that the

cost in stolen property is something on the order of half a billion dollars a year in the New York metropolitan area.

When you add in the cost of police forces necessary to cope with the crimes and the expense of our legal machinery and jail facilities, the cost of treatment and rehabilitation is dwarfed.

The thing this bill does not do is attack these huge costs to society and to the addict—of crime to obtain drugs, of stolen goods, of police, prisons and rehabilitation. Research should be begun at once to find a safe way to dispense nonharmful drugs to meet the addict's needs under proper medical supervision. Discovery of the new drug, methodone, offers great hopes to make the so-called clinic system, or English system, work effectively.

I would like to commend to the committee, if they have not seen them, two very excellent articles which appeared serially in the New Yorker magazine about the work of Dr. Nyswander, who did pioneer research with this drug. Apparently methodone, which is substitutable for the addictive drugs, will relieve an addict of his physical craving for narcotics but at the same time has none of the harmful side effects. Dr. Nyswander has had some very good results in relieving or stabilizing addicts, allowing them to go to productive lives.

In talking about the clinic system, or the English system, in the past the problem has been a medical one. Apparently the addict has an insatiable craving for drugs. The fear has been if we gave him the drugs he needed to feed his addiction and tried to stabilize at certain levels we would not be able to satisfy his craving. He would get what he could from the clinic system, and then go on and keep getting more. The discovery of methodone, I think, offers a possible way out of this problem, perhaps a way we could take away the incentive to crime by dispensing this drug to the addict. I think, before we do this, research is needed in this area. It is very worthy of exploration by this committee.

After considering the various aspects of action programs that can be adopted to attack this problem now, I have introduced and supported H.R. 9159 which I believe represents the best accommodation of the various suggestions that have been made up to this time. I am very much aware that it is only a start, but I think it represents the best way to begin.

We must be realistic, however. This will affect only a very small fraction of the total narcotics addicts arrested. The vast majority of addicts are tried in State and local courts which would not be bound by this law. But enactment of the legislation being considered today will mean that the Federal courts and Federal prisons will not be returning sick men to the streets to add to the rising toll of crime. Perhaps it will also chart a course for the same kind of cooperative interaction between State and Federal agencies that now exists in the area of enforcement.

By permitting an addict to be committed for treatment instead of punishment, H.R. 9159 affords him a great opportunity. Properly excluded from this opportunity program are those persons who are not suitable subjects for rehabilitation or persons whose criminal activity requires severe punishment.

In this respect, Mr. Chairman, I think that H.R. 9159 is far superior to the other bills that have been introduced in its provisions for ex-

clusion, a matter on which you received some comment in testimony this morning.

Remarking on this new approach, we must strive to include all who would benefit, but we must be careful not to be carried to extremes. If we go too far too soon, we may cause the program to fail and thus defeat the very humanitarian efforts that hold so much promise for the future. The restraints and limitations in H.R. 9159 are admirably geared to accomplish this.

Perhaps the most important aspect of H.R. 9159 is its provision for aftercare treatment in the addict's home community following his withdrawal and release from hospitalization. Medical authorities are unanimous in holding that aftercare is the key to a successful rehabilitation program.

In both the preconviction and postconviction treatment programs, H.R. 9159 authorizes the Surgeon General or the Attorney General, whoever is involved, to contract with any public or private agency or person for aftercare facilities or services. By establishing this broad contracting authority, it is hoped that local communities will be brought into this rehabilitation program and that the best facilities or services available will be secured. As you know, there is other legislation that has been introduced, which I also sponsor, which does provide measures to help local communities in acquiring facilities they may need.

This again is just a start on the extensive aftercare provisions that will be required. I am convinced that future legislation will be called for to establish more and more specialized aftercare facilities. Federal funds are needed to assist States in setting up adequate post-treatment facilities in local communities with the most serious problems. H.R. 9159 does not offer this, but the bill is a step in the right direction.

The new, humane approach to the problem of the addict should not be misinterpreted as a softening of our treatment of the pusher or dope peddler. H.R. 9159 does not lessen the penalties against the trafficker in narcotics who sells drugs for profit. This vicious parasite who capitalizes on the need of the sick and vulnerability of the young will be removed from society and punished. H.R. 9159 recognizes this by refusing to eliminate the minimum mandatory sentences applicable to the narcotics and marihuana offenses.

The approach we are considering today will help to cure the addicts we now have and should thus reduce the spread of the illness from that source. But I am convinced that we must find new ways to strike at the traffic itself, to cut off the supply or reduce the profit.

In the near future I am going to recommend reform of our laws to provide for more stringent penalties against peddlers. We too often hear at the present time of criminals in the trafficking business getting off very lightly with discretionary sentences, and I don't think any crime is more heinous than that involving a young person, really ruining his whole future, by getting involved in narcotics addiction. I will also introduce bills to expand and strengthen enforcement and to authorize research into new methods of treatment of addiction.

These are just three of the new measures that will be necessary to complete the new program to combat addiction in the United States.

I would also urge this subcommittee to consider provisions similar to a measure I introduced on May 4 of this year which would amend the Public Health Service Act to permit treatment of abusers of barbiturates and amphetamines at Federal hospitals. Few people realize at the present time Federal hospitals can treat people who have a narcotics addiction problem, but they are not authorized to treat people who are ill from the effect of barbiturates and amphetamines.

Most authorities appear to agree that barbiturate addiction is the prep school for narcotics addiction. If we could treat the barbiturate addict and amphetamine abuser who comes before Federal courts before he graduates to the higher education of narcotics, we could make a significant reduction in the number of narcotics addicts we are called upon to treat. I would like to file with this committee a copy of the bill I submitted to make such treatment possible.

I urge the subcommittee to consider this important extension of our treatment facilities, but regardless of the action that is taken on this proposal, I urge the committee and the Congress to act favorably on H.R. 9159—and now.

Mr. ASHMORE. Are there any questions?

Thank you very much.

Mr. OTTINGER. Thank you, Mr. Chairman.

Mr. ASHMORE. Thank you very much, Mr. Halpern. We are glad to have your statement, particularly since you put so much study and work on this throughout the year and we feel you are more or less an expert on the subject.

Mr. Senner, do you have any questions?

Mr. SENNER. I have no questions. I only want to thank my colleague for his contribution today.

Mr. HALPERN. Thank you very much, Mr. Senner.

Mr. ASHMORE. Mr. McClory.

Mr. MCCLORY. I want to indicate my appreciation also because the Congressman, I know, has a tremendous background of experience in this subject in the State of New York and it is really the background of experience that the States of New York and California have had that seem to impel this legislation.

I am curious about this aspect of the legislation and I would like to ask one or two questions:

The fear that I have is that we may be setting up a duplicate system or program at the Federal level patterned after the State programs but not fully utilizing the State facilities that are already in existence. Since this is a problem that is centered primarily in four States, I wonder if it is not sufficient if the Federal authorities are granted the same prerogatives and the same privileges now permitted under State laws in State cases, with the further provision that if the Federal authority is granted in Federal cases, that they might utilize the facilities and talents and skills of the State agencies and if that would not be an adequate answer.

Mr. HALPERN. I think one complements the other. I agree with you that the maximum of State facilities should be utilized, not only the physical facilities but the knowledge and experience in this particular field that has been gathered through the years on all levels, local, State, and Federal.

I think this legislation is vital. This legislation, so far as the civil commitment is concerned, only affects Federal crimes and there would be and the program does call for cooperation with the States.

The bills, as you know, have different approaches. The Celler bill would provide $15 million a year for 3 years and so forth and the Javits bill is somewhat similar to the Celler bill. The administration bill provides for no grants but the civil commitment aspect is limited to Federal offenses, and some of this legislation, mine, for example, is limited to offenses referring to narcotics and omits others. The Celler bill excludes those who deal in resale, and so forth. They have different approaches and I would think from the knowledge this committee will gather from the hearings and from your experts you can come up with the areas that should be covered by this legislation and the exclusions. But civil commitment is vital to any program to combat this scourge, as I call it.

Mr. McCLORY. That is all.

Mr. HOFFMAN. From the facts available from the hearings in the Senate Committee on Government Operations, it appears from statistics developed by the New York Narcotics Bureau—in New Jersey—that 77.2 percent of the addicts surveyed had a record before they became addicted.

Mr. HALPERN. Pardon me, were you quoting New Jersey statistics?

Mr. HOFFMAN. These were statistics developed by the New York Narcotics Bureau in New Jersey.

Now, the California Bureau of Narcotic Enforcement reported 97 percent of addicts, in their experience, had in their background evidence of antisocial behavior, including criminality, before they became narcotics addicts. Could you comment on that?

Mr. HALPERN. We can take figures out of context. I think the 97 percent is extremely high. It is a question of what you call antisocial behavior and what you call criminality.

Mr. HOFFMAN. The antisocial behavior includes criminality—criminal violations.

Mr. HALPERN. Including, but you do not have a separation of what might be antisocial. Obviously a person of normal pattern would not succumb to the use of drugs. In all the experience I have had with the many addicts I mentioned earlier with whom I had contact, you will find an antisocial background, not necessarily originating with the individual but in most cases with his physical environment, his family background, and a multitude of other causes that give him a somewhat antisocial background of behavior, and then they become addicted, if not to drugs in some other way. This is not just a question of taking them off drugs. That can be done easily. The big problem is the adjustment afterward, and that is why these programs of long range—one of the programs is 5 years and some are 3 years; I would like to see 5 years. I think we should try to adjust these people to society because they are all problems and the victims are not just the individuals themselves but society itself.

Mr. ASHMORE. Thank you very much, Mr. Halpern.

Mr. HALPERN. Thank you.

Mr. ASHMORE. We have one more witness, the Honorable Ogden Reid of New York.

STATEMENT OF HON. OGDEN R. REID, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. REID. Thank you, Mr. Chairman.

Mr. ASHMORE. Mr. Reid, I believe you have introduced legislation?

Mr. REID. Yes, Mr. Chairman; that is correct.

Mr. ASHMORE. I would be glad for you to file a statement for the record or briefly summarize it, whatever is your best judgment.

Mr. REID. Thank you very much, Mr. Chairman. It is a distinct privilege to have the opportunity to appear before your distinguished committee and I will take the opportunity, if I may, of your kind offer to provide a full statement for the record and I will try to be very brief as I know your time is limited.

As you indicated, I have introduced four bills. They were cosponsored in the Senate by Senator Javits and Senator Kennedy, and in the House by Representatives McCulloch, Springer, Lindsay, Mathias, Bell, Ottinger, and Delaney, to mention a few who have introduced these bills with which you are familiar.

The purpose of these bills, broadly speaking, is to come up with a full-scale approach to the problem of narcotics and to distinguish between the criminal "pusher" and the victimized addict who is in need of medical treatment, assistance, and rehabilitation and not a postgraduate course in crime.

The first bill deals with pretrial civil commitment instead of criminal punishment in certain cases involving narcotic addicts.

The second bill would modify the new mandatory prison sentences imposed on addicts to allow Federal courts more latitude in the use of parole, probation, and sentence suspension, particularly in cases involving youthful, first-time offenders.

The third bill would establish a Federal-State two-thirds, one-third matching grant program to provide a wide range of services and treatment to drug abusers.

And the fourth bill would create a Federal-State two-thirds, one-third matching grant plan for the construction or acquisition of needed facilities for medical treatment and rehabilitation programs.

I am aware only one of these bills is presently before the committee but I wanted to mention briefly we had introduced an overall package.

I have the honor to represent Westchester County, which borders on New York City and goes up to the Connecticut line, and I would mention just two figures: There has been a twelvefold increase in arrests for violations of the narcotics laws in Westchester County during the last 10 years. In 1955 in Westchester County there were 23 males and 2 females arrested. In 1964 there were 281 males and 42 females arrested in Westchester County for the possession or sale of narcotics. In 1964 in addition there were 12 deaths in Westchester County, 5 times the number of deaths or equal to the total number of deaths in the preceding 5 years. And in 1964 in Westechester County, of those 12 deaths, 10 were under the age of 21. So it is a matter of concern to Westchester County.

Finally, I would just say that there are several significant differences, with which you are fully aware, between the commitment bill that Senator Kennedy and Senator Javits and I have introduced and the administration bill. Essentially, our bill would deal with a period of 5 years rather than the 3 years of institutional treatment in the ad-

ministration bill. Second, the administration has not come up with funds for facilities for treatment and rehabilitation services. And finally, so far as I know, the administration has not come forward with any liberalization of the minimum mandatory sentences which some of us feel are indicated if we are to deal in a humane sense with the narcotics problem and make it possible for those that need treatment to get it in an appropriate facility and not necessarily in a prison.

Accordingly, I would merely like to add that we commend your committee for holding these hearings. I think it is a vital and important subject and I hope that the Congress, in its wisdom, will be able to act promptly on all the indications facing the United States in the field of narcotics, to meet the medical problem, and to do so with adequate funds for research and to keep the law stiff for the hard pushers, but be humane with regard to the victimized addict that requires basic treatment.

Thank you, Mr. Chairman.

Mr. ASHMORE. Thank you very much, Mr. Reid.

What is your idea of marihuana as an addict-forming drug? Do you think it should be treated in the same class as heroin, morphine, and cocain?

Mr. REID. I think experts differ, and I am not in that category, but in my opinion marihuana, while it is psychologically habit forming, is not as serious as heroin, and that is why some of us have introduced bills that would minimize sentencing as to marihuana. I do not think it is as serious as heroin and cocain. Medical opinion seems to differ but there is some opportunity, I would think, if we can deal with an individual who has just been on marihuana, to make progress. I think we have greater hopes of making progress with an individual who has just been on marihuana than with someone who has been taking hard narcotics.

Mr. ASHMORE. Mr. Senner.

Mr. SENNER. I want to thank my colleague for his fine statement. I do not know if your written statement which you were kind enough to insert in the record would cover this facet, but you gave figures for your district and you said there was a twelvefold increase. Has your population increased that much?

Mr. REID. No, it has not.

Mr. SENNER. I understood you to say it went from 23 males and 2 females arrested in 1955 to 281 males and 42 females in 1964. Have you made any breakdown or looked into the economic background or the sociological aspects of these drug addicts?

Mr. REID. Some research has been done but I would like to try to be fully responsive to that inquiry and ask the sheriff's office to supplement my information. But it is very clear there is an increase in teenagers. It relates somewhat to the availability of narcotics in the Bronx, but that is an oversimplification.

(The following information was submitted for the record:)

JULY 9, 1965.

Hon. ODEN R. REID,
Congressman, 26th District, New York,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN: With reference to House bill H.R. 8880 and for your advice and information I would state hereon that the various police departments in Westchester County made the following arrests during the year 1955 up to June 30, 1965:

Year	Male	Female	Year	Male	Female
1955	23	2	1961	84	27
1956	13	11	1962	129	21
1957	26	4	1963	256	24
1958	45	6	1964	281	42
1959	97	6	1965 (Jan. 1–June 30)	134	13
1960	67	5			

As you can see from the above years there has been an increase in the number of arrests made for violation of the various narcotic laws. The dangerous age appears to be between the ages of 16 through 21; although our latest figures show us the largest number insofar as ages are concerned is between 16 and 26. There is a definite need for a type of treatment for persons within these age groups, i.e., 16 through 26.

The bill, as outlined, in my opinion is a step in the right direction insofar as hospital treatment for these unfortunate persons is concerned. As I see by the records that we have pertaining to persons incarcerated in the sheriff's Westchester County jail at Valhalla, N.Y., we find that a total of 140 persons applied for hospitalization pursuant to the provisions of article IX in the New York State mental hygiene law and out of 140 who applied 46 were accepted which included 4 females. A review of the persons coming into our hands at the sheriff's Westchester County jail shows us that 14 percent of the crimes committed in Westchester County can be traced to narcotics addiction or influence. This is true in both the male and female inmates coming into our custody. The records further show us that the persons coming into our hands have had previous criminal records before they became addicted to the use of narcotics.

Assuring you of my continued cooperation in matters of mutual interest, I am,

Very truly yours,

JOHN E. HOY,
Sheriff, Westchester County.

Mr. SENNER. When did New York pass its narcotics remedial legislation?

Mr. REID. It was passed in 1962 and it is the Metcalf-Volker Act, as you perhaps know.

Mr. SENNER. I want to thank the gentleman for his fine statement.

Mr. REID. I thank my colleague.

Mr. ASHMORE. Mr. King.

Mr. KING. These persons who were convicted in your county—I assume they were convicted?

Mr. REID. The table I will submit for the record is a table of arrests. I will be happy to furnish figures on convictions.

Mr. KING. Do you know if they were treated under the new New York statute?

Mr. REID. I would like to answer for the record with accurate figures. My impression is the treatment has been very limited and there is virtually none in Westchester County.

Mr. KING. You mean they have not followed the statute?

Mr. REID. They have followed the statute but the opinion of the sheriff is the treatment facilities are very inadequate.

Mr. KING. Do you know if they would be treated in a county or in a State institution?

Mr. REID. They will be treated in a State institution but the availability of facilities is inadequate and it is the opinion of the sheriff there should be a facility in the county to deal specifically with narcotic addicts.

Mr. KING. What about aftercare in your county under the new New York law?

Mr. REID. It has frankly been limited. The law did not go into effect until January 1963.

I would like to provide some material that would be directly responsive to your question as to what the experience of the county has been during that period, but it has been insufficient, as I understand.

Mr. KING. Thank you.

Mr. ASHMORE. Mr. McClory.

Mr. MCCLORY. Mr. Reid, I certainly compliment you on your interest and your sponsorship of this important legislation.

I note you have taken the approach of introducing several bills which go together and link up a package.

Mr. REID. Yes.

Mr. MCCLORY. On the other hand, Congressman Celler has embodied the four bills into one comprehensive measure. You do feel, do you not, that this package of legislation would be effective if enacted?

Mr. REID. Yes; I do.

Mr. MCCLORY. You referred to 200-some cases in Westchester County. Do these include marihuana cases, do you know?

Mr. REID. Yes; they do. I would be happy to give the distinguished gentleman the breakdown.

Mr. MCCLORY. The marihuana cases would not be covered by this bill, would they?

Mr. REID. One of the bills we have here would allow Federal courts more latitude in the use of parole, probation, and sentence suspension. I would be happy to submit a section-by-section analysis of that bill.

Mr. MCCLORY. With regard to the treatment alternative, there is no provision for that in marihuana cases?

Mr. REID. There is no provision essentially, as I understand it, for marihuana cases.

Mr. MCCLORY. Marihuana is not a habit-forming drug?

Mr. REID. Some doctors say that while it may not be physically—perhaps that is not the right word—habit forming, it can be psychologically habit forming so there is a need for rehabilitation and treatment of users of marihuana.

Mr. MCCLORY. Is marihuana included in the legislation?

Mr. REID. The legislation which we have introduced would change the requirements relating to those who have been addicted with marihuana with respect to minimum mandatory sentences and parole, probation, and sentence suspension provisions.

Mr. MCCLORY. The real basis for that is, first of all, that a user of marihuana is not a serious offender and we want to be in a position to parole him to a private physician or something like that so that he is not confused with the serious offender?

Mr. REID. Yes.

Mr. MCCLORY. I think that is all I have.

Mr. HOFFMAN. Sir, you mentioned one of the differences between your bill and the administration bill lay in the treatment of mandatory minimum sentences and parole and probation in narcotics violation cases. I take it your bill would weaken the present strength of the law in those cases. Would you comment on that?

Mr. REID. I think essentially what Congressman McClory has been saying is correct. I think there is an opportunity for treatment and rehabilitation of marihuana addicts, if that is the proper term, and they should not necessarily have to undergo a sentence if they can undergo commitment and rehabilitation.

Mr. HOFFMAN. But do you think providing an alternative, which is civil commitment, is advisable to take the place of the strict penalty for the straight hard-core addict?

Mr. REID. Not for the strict hard-core pusher. I would, if anything, suggest strengthening the penalty as to the strict hard-core pusher. The committee will have to draw the line between the criminal pusher and the victimized addict. But I might add, in addition to stiff penalties in this area, I talked to the Bureau of Narcotics and I feel there should be additional funds for agents, and I think we have to do more to prevent narcotics from coming in this country from overseas. I saw much of that as U.S. Ambassador.

Mr. HOFFMAN. I think the operation of the Kennedy-Javits bills would relax the present strictures against parole in certain narcotics cases. Is that your impression?

Mr. REID. Yes.

Mr. HOFFMAN. In view of the figures we have of 1,800 Federal cases a year, of which 800 or 900 would be subject to civil rehabilitation, this would affect a number of addicts.

Mr. REID. It would relax a certain number; yes, sir.

Mr. ASHMORE. Thank you, Mr. Reid.

Mr. REID. Thank you, Mr. Chairman.

Mr. ASHMORE. At this time I would like to place in the record the statements of Senator Bartlett, of Alaska; Representative Springer, of Illinois; Representative Paul J. Krebs, of New Jersey; and Representative Delaney, of New York. They had planned to appear before the committee but could not be here.

(The statements referred to follows:)

TESTIMONY OF SENATOR E. L. BARTLETT, DEMOCRAT, OF ALASKA

Mr. Chairman, I am appearing before this subcommittee in support of H.R. 9051 and H.R. 9167, introduced by Chairman Celler. I am a cosponsor of similar bills in the Senate, S. 2113 through S. 2116, introduced by Senators Javits and Kennedy of New York, and S. 2152, introduced by Senator Dodd.

H.R. 9167 is similar to the Dodd bill and embodies many of the proposals made in the President's message on crime of March 8. It contains measures designed to rehabilitate rather than simply to punish the violators of Federal narcotics statutes. It would give the addict the option, in certain cases, of undertaking rehabilitation rather than of facing criminal prosecution. It would further authorize the court to sentence certain convicted violators to rehabilitative treatment. It would make parole available to all marihuana offenders and make sentencing under the Federal Youth Corrections Act available to all marihuana or narcotics offenders under the age of 26.

H.R. 9051 is a more comprehensive bill. It contains a pretrial civil commitment provision and a modification of present postconviction sentencing restrictions so as to permit a more flexible use of paroic, probation, and suspension of sentence as tools of rehabilitation. In addition, it institutes a Federal-State matching plan for facilities and services to treat addicts and to facilitate their reentry into their communities.

Our efforts at narcotics control for the past 50 years represent a narrow, unnecessarily cruel and inhumane approach to the problem. We have attempted to wipe out addiction in the populace by restricting the flow of the drugs themselves. Our laws have set stiff penalties for the possession or sale or transporting of narcotics. Have we been successful? The number of addicts is large

and growing larger; estimates run as high as 100,000. We have inadvertently contributed to the creation of a thriving and lucrative black market in narcotics. We have caused the price of drugs to skyrocket and made it almost inevitable that the addict engage in criminal activity in order to support his habit. We have made our addicts fearful of prosecution but have failed to realize that punitive measures are irrelevant to the treatment of the addict and, in fact, may aggravate or compound his problem.

It is often pointed out, however, that our laws have resulted in lowering the percentage of addicts in the population. It is true enough that, while 1 person out of every 400 was addicted before the passage of the Harrison Act in 1914, only 1 in 4,000 is addicted today. Perhaps the reduced availability of narcotics has reduced the magnitude of our problem in gross statistical terms. But there are few who would claim that the problem has been solved or is even approaching solution. On the contrary, the number of addicts is increasing and our theories and techniques for treating and rehabilitating present addicts do not nearly meet our needs.

There must be many questions asked, many problems raised, many solutions attempted. We are reminded time and again of the truth of Thoreau's observation: "There are a thousand hacking at the branches of evil for one who is striking at the root." Most of our previous efforts, I fear, have only struck at branches. I therefore welcome these bills and the interest of this committee as promising creative new approaches to what has become a serious and intractable national problem.

No doubt we must continue to restrict the flow of narcotics and to punish those who perpetuate and profit from their sale. But our focus must shift. We must recognize that dope addiction is a sickness, often indicative of other sicknesses. Accordingly, we must concentrate on the prevention of addiction, on its cure, or rehabilitation, and on the reduction of the frightful rate of relapses after "cure." This morning I will only briefly and generally mention four areas which I believe to be of particular concern.

First, there is a need for study and clarification regarding the extent to which physicians may use drugs in the treatment of addicts. There is a respectable body of scientific opinion which holds that it is desirable to maintain addicts on reduced dosages of drugs for a considerable length of time after treatment has begun. Experiments conducted in New York by Dr. Marie Nyswander and others (reported in the New Yorker, June 26 and July 3, 1965) have suggested that addicts might be maintained on methadone, a drug substitute which prevents the harmful effects of both continued addiction and precipitate withdrawal. At any rate, the data on ambulatory maintenance is far from complete. I am not at all suggesting that drugs be made generally available; careful regulation is necessary. But it does seem that, either by legislation or by clarification of existing regulations, doctors should be assured of their freedom to utilize and experiment with controlled dosages of narcotics in their treatment of addicts. The ambiguity of present regulations and the lurking fear of prosecution now causes many doctors to avoid treating narcotics altogether, or to resort to the unnecessarily harsh "cold turkey" withdrawal technique.

Second, there must be a recognition of the close linkage between an addict's disease and his criminal activity. Our narcotics laws occasionally apprehend the big-time operators who are free of addiction and who profit immensely from the misery of others. More often, those apprehended are middlemen, themselves addicts, who sell and transport narcotics only to obtain the $10 to $30 per day they require to buy their own drugs. These people need cure more than they need punishment; the purpose of the civil commitment bills is to make it available to them. Hopefully, a way can be devised to extend the civil commitment provisions not only to narcotics law violations but to other Federal infractions as well. It is hoped that State lawmakers would follow our lead in this regard. A number of experts, including the President's Advisory Commission on Narcotic and Drug Abuse, have stressed that a civil commitment program cannot be wholly voluntary. Often the addict fears or resists treatment, and he must often be held to treatment once it has begun. The combination of voluntary and compulsory elements contained in H.R. 9051 seems well advised.

We must greatly expand, in the third place, our research efforts and our facilities for treatment. The funds authorized in H.R. 9167 and the Kennedy-Javits Senate bills are badly needed. The treatment of addicts is a difficult and discouraging business, often unrewarding, financially or otherwise. Public

Health facilities for narcotic treatment at Lexington and Fort Worth are not adequate. Some promising research projects are underway, under the aegis of the National Institute of Mental Health, but they are only a beginning. We must encourage competent persons to enter the field of narcotic treatment. We must learn much more than we now know about the psychological and sociological roots of addiction, the various techniques of withdrawal and rehabilitative therapy, the problems of social reentry. We must realize that any effective confrontation of the narcotics problem will require facilities, personnel, and knowledge for medical treatment, family counseling, psychotherapy, vocational training, placement, and probation-type supervision.

This leads me to a final point: We must somehow deal with the environment that breeds the addict. Ofter he is a particularly unfortunate victim of the "subculture of misery" which, as Michael Harrington shows, characterizes "the other America," the America of the poor. Often the addict, like the alcoholic or social deviate, is seeking escape. It has been demonstrated time and again that, even after a trip to Lexington for the "cure," the need for escape will recur. So long as we do not alleviate the problems that led to addiction, even what little "curing" we are doing will reach the symptoms but seldom the disease. We must realize that narcotics treatment involves much more than physical withdrawal, and we must expand our research and facilities accordingly. And, of course, in the long run, we must alleviate the social misery that breeds this affliction.

It is much easier, Mr. Chairman, to point to problems and needs than it is to prescribe and implement solutions. I commend the committee for its efforts, and I again register my strong hope that these similar bills will soon receive congressional action.

Many national problems have we handled badly, but few as badly as that of narcotic addiction.

STATEMENT BY HON. WILLIAM L. SPRINGER

Mr. Chairman, I appreciate the invitation to present my statement concerning H.R. 8900, which I introduced and which was referred to your committee. The subject of narcotics and those addicted to narcotics has been a difficult subject upon which to legislate over the years. Too little was known about the proper approach, particularly in regard to treatment of addiction. The Harrison Act tried to make it extremely difficult for those who would traffic in drugs to obtain them. The severe restrictions placed upon the distribution of hard narcotics with its great inconvenience to legitimate sources such as pharmacists and doctors has been effective enough to justify its existence and the inconvenience which it causes. As you know, a new and equally menacing problem has grown from the use of stimulant and depressant drugs. These have been so easy to manufacture and distribute that the country was about to become flooded with these dangerous substances.

H.R. 2, which passed the House some months ago after consideration by the Committee on Interstate and Foreign Commerce, of which I am a member, provided for recordkeeping by those who manufacture and distribute stimulants and depressants. It tightened up the machinery to stop the counterfeiting of goof balls and pep pills. This bill has been passed by the other body and the White House has informed me that President Johnson will sign it into law this morning. It is as necessary as the Harrison Act and I am confident that it will keep millions of dangerous pills from the hands of our young people and other potential drug abusers.

Over the last few years a new philosophy for medical treatment for certain conditions has emerged. The tendency to hide mental affliction and mental retardation from public view and consideration is now giving way to a newer and thoroughly sound idea. The treatment for mental health conditions and also for mental retardation can best be accomplished if done at the local level when possible. At the suggestion of the medical fraternity we have passed laws providing for community mental health facilities and also community mental retardation centers. These will make it possible to attack the problems where they arise. Obviously this calls for new skills to be available at the local level but that problem is also being met through medical and health professions educational assistance.

Despite all this excellent progress, we have still neglected one vital area. Still with us from the dim past are the laws which treat a victim of narcotic addiction

or drug abuse as a criminal per se. We have tried to decrease excessive use of drugs by the enforcement of harsh and unbending laws, leaving no room for judgment or discretion to those charged with enforcement. The provisions for rehabilitation or treatment have been meager and have not been in line with today's medical thinking and the philosophy of treatment which I have earlier described. To correct this, a series of bills were introduced by several members, providing, as does my bill, H.R. 8900, for civil commitment of addicts; for discretionary powers in the courts and parole machinery; for rehabilitation services similar to those provided at State and local levels by present public health entities; and for construction of rehabilitation facilities. Taken together, these various proposals make a package to implement what I think is the modern, the proper and the most effective philosophy for handling narcotic addicts and drug abusers.

I will not attempt here this morning to discuss all of these measures, although I am aware that your bill, H.R. 9051, touches upon all of the things I have mentioned. There are two bills covering some of the subject matter in your bill, Mr. Chairman, which have been referred to the Committee on Interstate and Foreign Commerce. I will therefore be called upon to hear testimony and to pass judgment on those bills. I think it would be premature for me to comment at this time. I do want to discuss briefly, however, the idea of civil commitment for drug abusers, which is outlined in my bill, as well as in your comprehensive bill and those of several other colleagues.

The basic idea behind a civil commitment measure is to keep the unfortunate victims of drug addiction in the mainstream of society as far as that is possible. I am sure that despite our harsh laws the courts and enforcement officials are trying to make the best use of present facilities for rehabilitation and treatment. I would not be surprised to find that charges are dropped in some cases where the subject requests voluntary commitment. Experience has demonstrated only too well that completely voluntary commitment does not work. There is not enough incentive to keep the addict under treatment. He will usually give up the idea long before he is really ready for release. This results in no appreciable gain to society and a total loss for the individual. These bills which provide for civil commitment provide a handle by which the enforcement authorities may keep a firm hold on the patient and give him strong incentive to keep up treatment and to be truly rehabilitated and providing also for aftercare. It does not suddenly put him on his own, with all the terrible temptations which seem to afflict such persons. To make it as clear as possible, I would like to outline the six things which H.R. 8900 does:

1. It gives the person charged with violation of a penal law relating to narcotics an election. He may ask as a matter of right for rehabilitation and treatment. This does not mean that he can automatically receive it and the bill outlines conditions which would bar him.

2. The court having jurisdiction of the case will decide whether or not the person is eligible and if the court so determines, it may commit the prisoner to the Surgeon General for treatment and rehabilitation.

3. The bill provides for treatment as long as 36 months, but if the prisoner goofs up during this time he goes back to court.

4. If the prisoner makes it through treatment he then may receive 2 years of aftercare on a probationary basis. If during this time he goofs up he goes back to court.

5. If the patient makes it through treatment and aftercare and is judged to be rehabilitated, the charges against him are dismissed.

6. The bill also specifically removes the criminal stigma from one who has subjected himself to this process, although it has been necessary to find that he was in fact a narcotic addict.

Mr. Chairman, I think that this bill, as part of the package of measures aimed at reforming enforcement procedures, will do much to help our society to successfully combat the problems of narcotics and drug abuse.

STATEMENT BY REPRESENTATIVE PAUL J. KREBS

Mr. Chairman, last month I introduced H.R. 9249, which is a bill identical to H.R. 9167, and which I am convinced will go a long way in improving our society's means of winning a war against waste.

One cannot fail but become alarmed at a waste of human life approaching the figure of almost 60,000 Americans. Of the 55,899 active narcotic addicts through-

out the country, my home State of New Jersey stands fifth highest with 1,466.

Briefly, my bill and that of the administration would amend title 18 of the code and contains the following features:

(1) It would allow addicts facing criminal prosecution—with certain exceptions—to choose civil commitment instead of undergoing trial, and to be placed in the custody of the Surgeon General for purposes of treatment and rehabilitation. Of course, those who illegally sell the drugs—the pushers—and those with repeated felony convictions would not be given the option of choosing civil commitment, since they obviously are not considered suitable subjects for treatment and rehabilitation.

(2) It would modify present law requiring mandatory sentences, following conviction of criminal offenses, for narcotic drug addicts and would provide, instead, for indeterminate sentencing.

(3) It would establish the eligibility of narcotic drug or marihuana offenders between the ages of 22 and 26 to receive indeterminate sentence and conditional release under the Federal Youth Corrections Act.

(4) It would amend the Narcotic Control Act of 1956 by making the parole provisions of prior legislation available to all marihuana offenders.

(5) It would permit the Board of Parole to review the sentences of presently imprisoned marihuana and narcotic drug law offenders under the age of 26.

Mr. Chairman, as you well know, this bill is the product of many years of consideration and work by Federal Government officials and interested private organizations and medical authorities in the field. The White House Conference on Narcotics and Drug Abuse was called by the late President Kenedy in September of 1962. Many distinguished and learned citizens were brought together at that time to give the Federal Government the benefit of their combined experience and expertise.

As a result of the White House Conference, President Kennedy appointed a Presidential Commission to review its findings and to further investigate the problem of narcotic and drug abuse generally.

In November of 1963, the President's Commission submitted its final report, which contained 25 specific recommendations for Federal Government action. My bill incorporates several of the major recommendations of that report, taking form after more than a year of careful study and attention to detail by the Justice and Treasury Departments.

I recite this history of the background to this legislation merely to emphasize that it was not conceived in haste or without careful judgment as to its need and as to its effects.

As to need, I believe there can be no doubt. Although narcotic drug addiction is not, certainly, the major domestic problem of our time, it is nevertheless a serious matter—and one which holds a threat of even more serious consequences for the future. This is especially true for the Nation's large metropolitan areas, which are the centers to which addicts from all over the country appear to gravitate, apparently to be close to the illegal sources of their drugs.

My own State of New Jersey has long suffered from the presence of addicts in its larger cities—many of them coming from other parts of the country. The city of Newark alone had 676 active addicts as of December 31, 1964.

Newark thus has the seventh largest number of any city in the entire Nation. The State as a whole, with 1,466 known active addicts, ranks fifth in the United States.

The thing which alarms me and the citizens of New Jersey is the rapid increase, during recent years, in the number of new reported addicts within the State. In 1960, 141 of these were reported. By 1963 the number had risen to 225. But then, in 1964, it jumped to 355. That is over a 60-percent increase, Mr. Chairman, and that is why I speak of a threat to the future.

Now, the one fact which stands out clearly in history of narcotic drug addiction in this country is that we have had little success in rehabilitation of the addict-offender. After he serves his term, he returns to the same community, takes up association with the same people, and eventually reassumes the same pattern of life, with addiction its central motivating feature.

It should be obvious, then, that something is wrong with our methods. I, for one, firmly believe, Mr. Chairman, that the penal approach is wrong, and that we will start to get better results only after we begin to treat these unfortunates as the sick people they are.

I have no pride of authorship and would be happy to support any legislation recommended by this subcommittee with the prospect of better dealing with the social disease that addiction presents. Thank you, Mr. Chairman, for giving me this opportunity of appearing before this subcommittee on behalf of effective legislation to combat this wasteful illness.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., July 21, 1965.

HON. EMANUEL CELLER,
Chairman, Committee on the Judiciary,
House of Representatives, Washington, D.C.

DEAR CHAIRMAN CELLER: I am hopeful that the enclosed statement submitted by Dr. Kenneth Dollinger can be included in the hearings being conducted on narcotic legislation.

Sincerely,

PAUL J. KREBS,
Member of Congress.

Gentlemen, I am here today to plead for some legislation that will recognize that narcotic addicts are sick people and need physician's care. Police control of the addict is, I suggest, unwarranted.

This peculiar situation is not new in our history. Just a few short years ago the insane were policed, and even chained and beaten until courageous men smashed this prejudice. Freed from the threat of police action, physicians were then able to cope with the problem. The development and growth of psychiatry resulted, to the benefit of us all. Today the addiction problem suffers in a similar position.

The increased use of barbiturates, amphetamines, and narcotics has evoked great concern. More deaths are caused by overdoses of these drugs than by any other poison except carbon monoxide. These drugs, until recently, have been the problems of the big cities. It is now the problem of all of us. It is particularly pronounced in suburbia. One explanation for this, presumably, is that the anti-social behavior which accompanies addiction to these drugs often goes unnoticed in large metropolitan areas. In smaller residential communities, such as mine, detection is sometimes easier.

We in the suburbs tend to keep our eyes focused on the crabgrass and the two-car garage, and fail to recognize the goof-ball and narcotic as a threat to our youngsters. What is even worse, when a child is picked up for using drugs, even the local school authorities rarely are notified. Worst of all is that even if they were notified little or nothing would or could be done for either the drug user or his unsuspecting classmates.

Our educators seem convinced that the dispersing of any knowledge regarding drugs to students will evoke an inquisitive reaction resulting in the possibility of trying these for "kicks." I believe very strongly that this is not the case.

The causes of drug addiction are known to you all. It basically occurs in individuals who are psychologically unstable. In addition idle curiosity coupled with parental indifference appear to be common denominators.

Teenagers especially are attracted to amphetamines because they tend to give the user the courage to perform recklessly. He then becomes a menace to himself and others.

Delinquency, including narcotic addiction, is thus seen as a phenomenon mainly attendant to certain forms of child-parent interaction. It is generally accepted that the youthful offender, whether he acts out through rebelliousness and irresponsible behavior or seeks a "solution" through the effects of drugs, is manifesting outwardly the symptoms of inner emotional disturbances.

Although a number of approaches have been attempted with the youthful offender including incarceration, discipline, and psychological referral, the results have not been too gratifying. For one thing adolescents are not ready to accept adult standards. They have a type of subculture.

We in Livingston, N.J., have set up a program concerned with the rehabilitation of these young addicts and soon-to-be addicts. This program is in the form

of compulsory group therapy, backed by the courts. This group therapy, we believe, has the best chance of success because of the rapport youngsters have with their peers. The court serves as the lever to enforce both the youngster and his parents to participate.

The enclosure is a summary proposal sheet of our project.

The legal and medical professions are now alerted to this national threat. An exact definition of the framework wherein police control and medical control functions is needed. The haziness of the dividing lines must be recognized.

SUGGESTIONS

(1) Legislation is necessary to control and curtail the amount of these drugs manufactured and distributed. There are more barbiturates available than are needed for therapeutic purposes. Over 700,000 pounds are manufactured in the United States each year which allows approximately 17 doses for every man, woman, and child.

(2) The addict must be treated, not prosecuted. He is to be recognized as an ill person and not as a criminal. The addict should be guided to our hospitals, and not forced into the underworld and eventual disgrace and oblivion.

(3) The Harrison Act was never intended to keep ill people from physicians care.

However, under our present laws most physicians shy away from treating this disease because of fear of the law.

Many physicians state that they "report addicts to police officers," or would not test addicts because "they were told not to."

S. Bernard Wortis, M.D., dean of the New York Medical School has noted that narcotic addiction is the only disease with its accompanying physiological and mental disturbances that the physician is forbidden to treat under penalty of law.

(4) We need more facilities. The Assistant Surgeon General of the United States (February 1963) Dr. James V. Lowry, "In the United States, jails are open to addicts, but hospitals are commonly not. Many addicts are too ill to overcome the compulsion of addiction and seek treatment, but if facilities were available such addicts could be involuntarily hospitalized. Unless hospitals are available for actual treatment, civil commitment laws are useless legal instruments."

(5) Enact more stringent laws against sellers of narcotics.

STATEMENT OF HON. JAMES J. DELANEY, OF NEW YORK

Mr. Chairman and members of the subcommittee, I appreciate this opportunity to present to this distinguished body my views on H.R. 9051 and related bills concerning civil commitment and other measures designed to attack the growing problem of drug addiction.

For many years I have been concerned about the use and abuse of drugs and narcotics. Because of this concern, I introduced on June 9 legislation which, like H.R. 9051, is designed to marshal the forces of Federal, State, local, and private agencies in a grand alliance to defeat this monstrous menace of drug addiction. I firmly believe that all segments of our society must work together with vigorous determination in a militant attack upon this vicious social enemy.

Like most Americans, too, I am deeply concerned about the increasing crime rate and its close relationship to the growing incidence of narcotic and drug addiction. I am equally concerned about the corrosive effect which this addiction has upon the lives of its victims and their families. On the other hand, I firmly believe that the person who trafficks in drugs and narcotics—the "pusher"—should be prosecuted to the full extent of the law.

The Federal response to the menace of addiction traditionally has been the application of a rigid set of criminal laws which do not differentiate sufficiently between the "pusher" and the victim of addiction. This Federal approach has been tried and found wanting. Clearly, it is now time to approach this problem with new perspective which will distinguish between the sick person and the felon. This will require an enlightened change in our laws so that a meaningful program of research and rehabilitation of these addict victims may be developed.

In an effort to effect meaningful legislation we must not only modify the statu-

tory penalties against victims of this vicious habit, but also concentrate a substantial portion of the Nation's resources, and the talents of its professional and scientific community in a dramatic program designed to exorcise this growing evil.

To this end, the legislation which I introduced, like H.R. 9051, makes a four-pronged attack on this ominous problem:

1. In lieu of criminal prosecution, it authorizes pretrial civil commitment for medical treatment of those charged with narcotics offenses, except for sale with intent to resell.

2. It modifies the harsh present postconviction sentencing restriction, so that Federal courts may use parole, probation, and suspension of sentence as tools to rehabilitate convicted defendants, particularly youthful offenders.

3. It establishes a Federal-State two-thirds, one-third matching grant program to provide a wide range of services, job training, and psychiatric treatment to ex-addicts to enable them to reenter society.

4. It creates a Federal-State two-thirds, one-third matching grant program for construction or acquisition of needed facilities for medical treatment, especially outpatient clinics for the crucial aftercare period.

I enthusiastically support this legislation, because it is designed to give the addict some incentive to rehabilitate himself successfully so that he may return to society and contribute his talents to the betterment of his family and the Nation.

Mr. ASHMORE. We will recess at this time subject to the call of the Chair.

(Thereupon, Subcommittee No. 2 of the Committee on the Judiciary recessed subject to the call of the Chair.)

BILLS PROVIDING FOR CIVIL COMMITMENT AND TREATMENT OF NARCOTIC ADDICTS

THURSDAY, AUGUST 5, 1965

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE NO. 2 OF THE
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 o'clock in room 2237, Rayburn House Office Building, Hon. Robert T. Ashmore (chairman of the subcommittee) presiding.

Mr. ASHMORE. The subcommittee will come to order.

We shall resume our hearings on the narcotics bills. A number of bills have been introduced on this subject. Two bills have been introduced by Mr. Celler, the chairman of our full committee, H.R. 9051 and H.R. 9167. One is known as the Celler bill and the other is known as the administration bill. A number of bills have been introduced by various Members of the House, and we are really considering all of them at these hearings, but we shall devote most attention, probably, to H.R. 9051 and H.R. 9167.

Today we have several witnesses listed who are known to be experts in the field of narcotics due to their experience, background, and training, all from the State of New York, I believe.

The first witness is Mr. Bert Gelfand, assistant district attorney, Bronx County, N.Y.

Mr. Gelfand, we shall be glad to hear from you at this time.

STATEMENT OF BERTRAM R. GELFAND, ASSISTANT DISTRICT ATTORNEY, BRONX COUNTY, N.Y.

Mr. GELFAND. Thank you, Mr. Chairman.

My name is Bertram R. Gelfand. I am an assistant district attorney in Bronx County, N.Y., and a member of the legislative committee of the New York State District Attorneys' Association. I am also in charge of legislative matters for the district attorney's office of Bronx County.

On behalf of the Honorable Isidore Dollinger, district attorney of Bronx County, N.Y., and a former Member of the House of Representatives, and myself, I wish to thank this committee for the opportunity of presenting the view of Mr. Dollinger and his office with reference to the legislation presently pending before this committee in the narcotics field.

It is doubtful if there is any area of law enforcement requiring the development and implementation of aggressive programs more than

the field of narcotic addiction. The latest statistics of both the Federal Bureau of Investigation and the New York City Police Department reflect that throughout the last several years there is a disturbing annual increase in the number of crimes commmitted. In the city of New York, where almost half of those addicted to narcotics are presently located, a majority of the crimes perpetrated are committed by those addicted to narcotics.

To illustrate, in 1963 there were 49,000 burglaries committed in the city of New York. Collectively they involve millions of dollars of property of decent citizens. Most of these burglaries were of a comparatively petty nature and are committed by narcotics addicts in their ever-increasing feverish quest for funds to obtain the drugs needed to satisfy their habit. The same general statement would be applicable to the great volume of larcenies that are committed, as well as to those women involved in prostitution and men and women involved in the distribution of narcotics to fellow addicts.

It must be conceded that under programs in existence at the present time, law enforcement is losing its battle against the ramifications of narcotic addiction. So long as the victims of narcotics remain addicted, it must be recognized that the requirements of their habit will compel them to commit crimes in order to obtain funds to satisfy the needs of their habit.

The bills of Congressman Celler and Congressman Gilbert—H.R. 9051 and H.R. 9886, respectively—in the opinion of our office represent a worthy, realistic, and commendable effort to implement a new and aggressive approach to coping with the narcotics addict who becomes involved in criminal acts. Of the utmost importance is the fact that these bills recognize that it is meaningless to enact into law even the finest theoretical program without the appropriation of adequate funds to effectively implement the program. A program which is not adequately financed will not lend itself to a proper determination of its efficacy, nor can it have any impact upon the problem.

To embark upon a program which is not adequately financed is more foolish than no program at all, since whatever funds are expended in an inadequately financed program are wasted, which has somewhat been the experience of the State of New York with its attempt at a similar program.

Those of us in State law enforcement are further heartened by these bills in that they allow the use of Federal funds to effectuate an adequate antiaddiction program with reference to those who come in conflict with the law on the State level. The problem is necessarily of the greatest importance on the State level since the majority of addicts do come in conflict with State law rather than Federal law.

The appropriation of money on the State level offers the opportunity to truly test a program such as that existing in the State of New York which yet, we must concede, remains untested due to inadequate appropriation of funds to implement it on any significant level.

The importance of this appropriation of funds to the State cannot be overestimated, as I stated, since the great majority of addicts come in contact with State law enforcement rather than Federal. Congressman Celler's and Congressman Gilbert's recognition that narcotics addiction attacks the very fibers of a decent community to the greatest

extent on the local level is evidence of a most acute understanding of a serious problem.

A program similar to that outlined by the proposed legislation has been in effect in the State of New York since 1963. This program's effects on the individual addict must be classified as untested to this date since it is our view that it has not been applied in a sufficient manner to a sufficient number of addicts.

Mr. ASHMORE. What are some of the primary reasons that it has not been successful?

Mr. GELFAND. I would not say the program has not been successful. I would say it has not been adequately tested due to the failure to create a sufficient number of facilities and the appropriation of sufficient funds for the after psychiatric care of those committed to the program. The critical period with reference to these addicts is actually the period after their institutionalization when they are placed on the street on parole. That is the time when they are in danger of losing all of the benefit of the institutionalization by reverting back to the use of narcotics.

Mr. ASHMORE. What kind of program do you have for aftercare?

Mr. GELFAND. On the theoretical level it is a psychiatric program, but unless there are adequate funds, it remains entirely on the theoretical and not the practical level. There must be funds appropriated for intensive psychiatric supervision after they leave institutionalization if there is to be any hope of the program having any effect. There must be the closest supervision of these people, and to institutionalize them for 1 or 2 or 3 years and then discharge them as detoxified and have them return, without stringent supervision and guidance, to the exact same atmospheres and circumstances that led to their prior addiction is a waste of the entire effort while they are institutionalized, Mr. Chairman.

Mr. ASHMORE. Do you try to keep them from returning to the old environment, friends, and neighbors? What is your effort in that regard?

Mr. GELFAND. The New York program I would say has not been successful in that it does not have the adequate aftercare facilities to keep these people from their old friends, old associations, and the very atmosphere and environment that led to their original problem.

Mr. ASHMORE. That is your objective, is it not? That is what you feel should be done?

Mr. GELFAND. Yes, Mr. Chairman. It is of the utmost importance, in order to accomplish any permanent rehabilitation, that these people not be returned to the same environment that led to their original problem. Unless there are funds for stringent afterinstitutionalization care, unless there is both tight control and extensive care, they naturally drift back to the same environment and to the use of narcotics and exposure to the same pressures that led to their original addiction.

Mr. ASHMORE. What do you think should be done to prevent them from returning to the same atmosphere and environment? Would you move them to another neighborhood?

Mr. GELFAND. I would say, Mr. Chairman, they can be moved to another environment only if some opportunity is offered for their adjustment to the environment, and they are incapable of doing that

on their own unless they have the guidance and care of proper professional personnel after their institutionalization.

Mr. ASHMORE. Does your program provide such professional care and guidance?

Mr. GELFAND. It does, but it is inadequate considering the number of people involved.

Mr. ASHMORE. What action would you take to get them out and look after them and provide a job for them and a means of livelihood after they leave the institution?

Mr. GELFAND. I would say from the moment they arrive at the institution, a plan should be laid out foreseeing their discharge into employment which they can cope with, and psychiatric care so the pressure of this employment does not lead to a reversion to addiction.

Mr. ASHMORE. When they get out, what would you have them do? Visit a psychiatrist every so often or a psychiatrist visit them or go with the probation officer to see them? What kind of psychiatric supervision do you have in mind?

Mr. GELFAND. Mr. Chairman, if I may elaborate in answer to your question, one of the problems is that statistics seem to indicate that almost half of the narcotics addicts in the United States are in the city of New York. They are necessarily in comparatively small geographic areas of the city. As long as there are so many people addicted to narcotics in the same area, I think it is fruitless, with the best care and even daily psychiatric visits, to believe that you can return someone to an atmosphere where there is so much concentrated addiction and hope that he would remain cured.

Mr. ASHMORE. I do not believe you can do it, but what action is necessary to prevent him from doing it?

Mr. GELFAND. For one thing, many of them have drifted into the city of New York from other areas, and they should be returned to their original situs. The conglomeration of addicts should be broken up. They should be returned to smaller communities where supervision is easier than in the anonymity of a large cosmopolitan area such as New York or Chicago or Detroit.

Mr. ASHMORE. This would involve a lot of money. Have you any idea how much? Have you any figure on that?

Mr. GELFAND. I can agree with you, Mr. Chairman, that it can involve a lot of money, and I cannot place my finger on a specific amount, but in contrast to the money necessary to diminish the number of addicts is the great amount of money involved today in the repeated crimes being committed by these people, their penal treatment, and the millions and millions of dollars of property being lost by the crimes they commit to obtain money which they then feed into the coffers of organized crime with all of the ramifications of such an occurrence.

Mr. ASHMORE. Do you think this should be done by breaking up the groups and sending them to some other area or some other State; in other words, getting them out of this environment? Could that be provided by the Federal Government? Would the State of New York be willing to go into it and cooperate financially?

Mr. GELFAND. Of course, Mr. Chairman, I cannot speak for what the Legislature and the Governor of New York would or would not be willing to do, but if the Federal Government is going to allocate funds

to the State for institutions, this money would be wasted were not the allocation capable also of being applied to the aftercare. Half a treatment is as worthless as no treatment at all.

Mr. KING. I thought in the legislation we were considering we were concerned with about 1,000 or 800 people. It is not my thought that we are going to establish some program to take care of all the narcotics addicts in New York, Chicago, Detroit, and California. Is that so, Mr. Chairman?

Mr. ASHMORE. Not necessarily, but I thought we should get some ideas on how it could be done or should be done or what they recommend be done.

Mr. KING. I thought the line of the questions that you were asking, Mr. Chairman, was very fine, and I wondered this: Do you propose to exile these people from New York?

Mr. GELFAND. I do not think it is a question of exile, Mr. King. I think you have a situation where the knowledge that there are so many addicts in the city of New York has created a situation where those addicted from throughout the United States are gravitating to the large urban areas, and by doing this we are facilitating the illicit sale of narcotics in that we are bunching all of the customers in a ready market where those who prey on their habits can easily distribute narcotics to them.

Even if you choose to use the word "exile," if we returned them to diversified environments from which they come, this in itself will make more difficult——

Mr. KING. How can you keep them out of New York?

Mr. GELFAND. You have control over them for a 5-year period, 2 years of which can be on probation. If this is a condition of probation, if you keep these people straight, so to speak, for the 2-year period, I think we would be a long way toward a cure. At this point we are getting nowhere with this problem. At least, under the pending bills, even if the amount of money involved applies only to 800 or 1,000, if it can be established that this is a program to solve the problem, I think we would then find the States more ready to appropriate money into such a program.

At this point there are countless proposals, but nothing is being implemented and nothing is being placed through the hard crucible of experience to determine whether or not this is a program under which we can go anywhere.

Mr. KING. In New York it has been in operation only 2 years, has it not? That is hardly time to find out whether it does work, is it?

Mr. GELFAND. Even a 2-year period, frankly, Mr. King, has not been an adequate test because they have not appropriated sufficient funds to apply——

Mr. KING. Regardless of funds, you have not had time to determine whether it is a good program or not.

Mr. GELFAND. Even those 2 years are wasted. It is not a question of time. We have not had enough experience in the 2 years to be on the way to testing the program because it has not been applied to a sufficient number of addicts.

Mr. SHATTUCK. There are certain guidelines that are established, however. You feel this is a problem which requires that a great deal

of supportive assistance be given these individuals after they are put back into society?

Mr. GELFAND. There is no question about that.

Mr. SHATTUCK. This is a firm fact, is it not?

Mr. GELFAND. Most assuredly; yes.

Mr. SHATTUCK. There was one point you made which, with your permission, I would like to explore a little bit further.

Mr. GELFAND. Certainly.

Mr. SHATTUCK. These individuals need this support. They need support from their families. Many of these people are in an urban situation where they have been cut off from the normal kind of strength that may come from a family. The family may be broken up. They may come from areas away from New York. They may be in a strange environment due to the fact that they are of different nationality or racial background. All of these are factors.

But the one thing that I would like to clarify is my impression that you cannot keep these people away from their general environment, out of their family circle and their community background entirely. They have to learn to cope with those problems eventually.

Mr. GELFAND. No; you cannot. You have a situation where a great many of those who have gravitated to this urban environment have done so solely motivated by their need and quest for narcotics, and narcotics are readily available to the addict in the urban areas where addicts have gravitated. Most of these people would not even be in this environment were it not for their desire to obtain narcotics to satisfy their habit.

Mr. ASHMORE. Do psychiatrists now believe if they keep these people away from their old environment, after they have cured them, taken the desire from them, they are more than likely to stay on the straight and narrow path, or will they drift back of their own volition without any encouragement from others?

Mr. GELFAND. Mr. Chairman, I do not think it is a view limited to psychiatrists. I think we can all accept that the hope of keeping an addict detoxified in an atmosphere where narcotics are as readily available to them as this ash tray, which is a foot from my hand, is available to me, is a nonexistent hope. Whatever chance there is with reference to these addicts is lost if they are immediately paroled into an atmosphere where narcotics are virtually at their fingertips.

There are areas in the city of New York where we must concede that addicts can obtain narcotics as readily as you might buy a pack of cigarettes.

Mr. ASHMORE. Maybe I did not put the question clearly. Are these people of a type who are innately weak and cannot resist their own desires and temptation for this stuff, or are they of such nature that they can be cured of the habit by psychiatric treatment if they are kept away from it?

Mr. GELFAND. The psychiatrists tell us that they are innately weak and that their addiction usually springs from their inability to cope with the normal problems of life and a maladjustment to society. Of course, there is no uniform truth that could be applied to everyone, but if these people can be adjusted to cope with their problems by psychiatric treatment, the psychiatrists feel that the cause of addiction in many cases will have been reached.

Mr. ASHMORE. Although they are innately weak in that regard.

Mr. GELFAND. If they were not innately weak—"innate" might not be the proper term, since sometimes their weakness springs not from a physical weakness but an environmental weakness or a weakness in training or in background or education or family ties. These are the weaknesses which can be rectified by psychiatric treatment.

Mr. ASHMORE. Does the medical profession know the difference between one who goes into it from an innate weakness or one who goes into it because of influence and environment?

Mr. GELFAND. I would say, Mr. Chairman, this is a sufficiently subjective field that we can determine how much the psychiatric care can accomplish only if we are willing aggressively to embark on a program and test it in the hard crucible of experience.

Mr. GILBERT. May I say that I am very appreciative of your remarks with reference to the atmosphere of the treatment of narcotic addiction. Coming from an area which has a high degree of narcotics users, I am very much aware of the problem. I always have been concerned about the environment that the addict resides in and subsequently returns to after he is released from prison or even after he is released from the hospital at Lexington or some other institution. Invariably we find that these addicts immediately return to their old ways.

So, the aftercare program is the most vitally important in the entire picture, because we are just wasting money, time, and effort in taking all these actions if, after an arrest, we institutionalize the addict and then return him back to the community. We might as well not start into the program, because I think there are very few who would be affected by the effort to cure them.

The question arises in the Federal program and bill we have before us today, to which Mr. King alluded a few minutes earlier, this would not affect a great many people because I think from your experience, Mr. Gelfand, at the Federal level the crimes committed by drug addicts probably are very infinitesimal compared to the State of New York.

Mr. GELFAND. That is true, Congressman.

Mr. GILBERT. Assuming we adopt the legislation we have before us, whether it be the Celler bill or any other bill, and we initiate this program, what impact do you think that would have upon the narcotics users throughout the country?

Mr. GELFAND. The provision of the bill which provides for the allocation of the funds by the establishment of institutions in the States and the appropriation of the moneys to the States is the factor which gives rise to the most enthusiasm among State law enforcement people, Congressman. As you point out most correctly, most of the addicts come in conflict with State law enforcement. By the allocation of these funds to the States, the State may establish adequate institutions and adequate aftercare programs which can be utilized by the States with reference to addicts who come in conflict with State law, while the facilities are still available for those who come in conflict with Federal law. It would be reaching the problem both on the State and Federal level in one swipe, rather than limiting it to a very narrow area of the few addicts who come in conflict with the Federal law.

Mr. ASHMORE. Is that true throughout the country, or is that just true in New York, with regard to coming in conflict with the State law?

Mr. GELFAND. I would say it would be true nationally. You find very few addicts committing crimes such as violations of the bankruptcy law or conspiracies or any crimes which involve even severe acts of violence such as armed robbery.

Mr. ASHMORE. You find them violating the law in the sale of narcotics.

Mr. GELFAND. These are people who are mostly on the higher level of the illicit narcotics traffic and people who, in our view, are probably better subject to penal than rehabilitary treatment. Those we are concerned with on the rehabilitation level are the souls who are committing 10 and 15 burglaries a week in order to obtain enough money to satisfy a $10- or $15-a-day habit, the young girl who is driven into acts of prostitution in order to satisfy a $20- or $30- or ultimately a $50- or $100-a-day habit. These are the ones who can be helped, rather than those who are involved in the wholesale smuggling, processing, and sale of narcotics.

Mr. ASHMORE. There is not much hope to reform them in the first place.

Mr. GELFAND. I hold very little hope and less sympathy for that person, Congressman.

Mr. GILBERT. Has the State of New York a specific program for aftercare of narcotics users or addicts?

Mr. GELFAND. It has an aftercare program, but it is so totally involved with the general parole and probation system of the State of New York and the great volume of individuals that it deals with, that without the appropriation of further funds, the impact of this program has yet to be felt on any significant level.

The effect of a true aftercare program remains untested. Unless we get the opportunity to test such a program, we are not in a position to know if we are even on the right path.

Mr. GILBERT. Is it your feeling, then, that there should be a separate parole system for narcotics users as opposed to other parolees?

Mr. GELFAND. Quite definitely, Congressman. It is an entirely different problem. You cannot equate the problem of paroling an armed robber into the community with returning a narcotics addict, where you are primarily interested in his physical and medical problems as against his conduct unrelated to the addiction problem. This is a peculiar problem which must be dealt with in a peculiar way. Dealing with it within the framework of established parole and probationary systems has proven ineffective to this time.

Mr. ASHMORE. Has the State of New York a separate parole office and supervision for narcotics cases from its general parole system?

Mr. GELFAND. The parole and probationary offices are not limited just to narcotics addicts, to my knowledge. There has not been the specialized application.

Mr. GILBERT. In the State of New York there are probably many voluntary agencies which are interested in this problem. Do you know from your experience whether any of these agencies have experience which would be of benefit to the committee with respect to their aftercare programs? I am thinking specifically of the halfway houses.

Mr. GELFAND. I am sure their experience would be of value, but from the viewpoint of law enforcement, the shortcoming of the voluntary program is the inability to exercise any compulsion over the

addict. Experience has shown that most addicts want to remain off narcotics, but they are incapable of doing so without proper guidance. Only under a bill such as the proposed legislation, where a degree of coercion can be exercised over these people, where they face institutionalization, or possible penal treatment unless they cooperate in the program, can they remain subject to supervision for a sufficient period of time to test the methods being used to detoxify addicts.

Mr. ASHMORE. You may proceed with your statement, Mr. Gelfand.

Mr. GELFAND. As I indicated, the State of New York has a program similar to that proposed by the legislation. However, the program in the State of New York is somewhat broader than the two bills I have referred to previously, in that it is not limited to those who come in conflict with the law for crimes involving narcotics. To that extent we favor the provisions in administration bill H.R. 9167, which would apply this program to all people who come in conflict with the law, rather than just those who come in conflict with the narcotics law, although we find that bill falls totally short in other areas, such as the appropriation of funds to implement the progam in that it just speaks of a program without implementation.

It would be recommended that the Federal legislation be broadened in a manner similar to the New York law, since necessarily the law's only contact with narcotics addicts does not involve the violation of narcotics laws, but touches upon a multitude of crimes.

It is further noted that under the proposed bills previously discussed, an addict has a mandatory right to obtain civil commitment rather than penal treatment. Conferring this right upon criminal defendants can represent a serious danger in many cases in that pressing circumstances involving the public safety may require, in the interest of justice, that a particular defendant be isolated by a penal sentence rather than civilly committed as a narcotics addict.

To illustrate, someone who might commit dangerous crimes of violence, when apprehended for these crimes may turn out also to be an addict. It certainly would be a sacrifice of the public safety to permit this person to immunize himself from penal treatment merely because he is also an addict, or a situation where someone is involved in the narcotics trade on a major level and his isolation from the community is in the best interest of the community, whether he be or not be an addict.

Mr. GILBERT. If you have an addict who commits a crime of violence, such as serious assault, but still it stems from the fact of his narcotics addiction, do you feel he should not be given the opportunity to have a civil commitment as opposed to criminal?

Mr. GELFAND. No; I do not feel that is so. If his problem stems totally from his narcotics addiction, there is no reason that he should not receive the benefit of this program. If his problem obviously also stems from a multitude of other factors and the mere cure of his narcotics addiction will not make him a fit subject to be in a free society, then he should not be subjected to the program.

I think it is a question that can be evaluated only on the individual level. With that in mind, I have a further recommendation: I recommend that discretion be vested in the prosecution, as it is in the State of New York, to veto whether or not a particular defendant shall have the right to participate in a civil commitment rather than penal treatment.

Mr. ASHMORE. You mean the prosecution and the judge, too, or would you leave it entirely up to the prosecution?

Mr. GELFAND. I have no strong feeling as to whether it should be in the hands of the prosecution and the court or the prosecution alone, but there should be authority in a competent jurisdiction to deal with each case individually to determine whether the background of the defendant makes him a worthy subject for this program, that he can receive useful benefit from the program without undue sacrifice of the public safety, or whether or not his individual background and public safety require that he receive penal rather than rehabilitary treatment.

Mr. SHATTUCK. Do you feel that this should be solely within the judgment of the court? Do you feel the exclusions in the administration bill H.R. 9167 should be taken as a guideline?

Mr. GELFAND. I feel the exclusions in H.R. 9167 are reasonable exclusions, but I feel it would be best if it were discretionary. As you gentlemen have pointed out, this program can only be applied to a limited number of addicts, and it would be helpful if, on an individual basis, competent courts and prosecutors who have the full background of the particular defendant could limit its application to those who could receive the most fruitful benefit from its application.

As I have stated, the limited facilities which would necessarily be available dictate that civil commitment not be available to every defendant. Then, there being limited facilities, it should not be applied to any defendant unless it is certified to the court involved that a facility is available to accept the defendant for a civil commitment.

It would involve a gross miscarriage of justice if those who have committed crimes are immunized from criminal action to be placed in a program that they shall never enter due to insufficient facilities, and if defendants have a mandatory right to enter this program rather than be criminally prosecuted, we may find a situation where the 1,000 or 2,000 or 10,000 beds available are completely exhausted; they would receive no treatment at all under the program and they would not be isolated from society.

We would then have a situation where we would be sacrificing the public safety without any treatment of those committing crimes, when facilities are not available for the rehabilitation program. To do that, we would be just turning them loose to continue committing the crimes they have been committing in the past to satisfy their habit.

Mr. ASHMORE. Do I understand you interpret the bill to mean that the mandatory certificate of these people be given the opportunity to accept civil commitment?

Mr. GELFAND. I so interpret the language of the bills, Mr. Chairman, and I find no specific reference to discretion in either the court or prosecutor, or the right of the court or the prosecution to specifically say that they wish this defendant to be criminally prosecuted for the crime that he has committed, rather than immunized from such a prosecution by a civil commitment.

I notice the bill uses the word "may."

Mr. ASHMORE. The court is not required to offer the individual the opportunity to elect to submit to the examination to determine his eligibility for civil commitment and this in itself will determine whether or not he will accept.

Mr. GELFAND. If I have misinterpreted the bill, I certainly enjoin the bill having that meaning.

Mr. KING. Do you mean it should be mandatory?

Mr. GELFAND. No; it should be discretionary.

I would further recommend that since this program does involve the appropriation of money to the States—and it is unrealistic to believe that facilities that are contemplated under the proposed legislation could be constructed in every State—that provision be made for an interstate compact which would allow State prisoners from one State to be committed to narcotic facilities of another State on a reimbursement basis when space is available.

I think this would be particularly important and I don't believe under any program facilities could be constructed in 50 States and in the case of many States there may not be the necessity for a separate facility while they may have a number of individuals who could benefit from the use of the facilities. And, since Federal funds are involved, I see no reason why there should not be a universal application of the benefits of the program.

Thank you again for the oportunity to present the views of District Attorney Dollinger, myself, and the office of the Bronx County district attorney.

Mr. ASHMORE. Thank you very much for coming in and testifying before us.

Are there any questions?

Mr. GILBERT. I merely want to thank Mr. Gelfand for appearing here this morning and giving us the views of District Attorney Dollinger. I believe the testimony has been most helpful to the committee.

Mr. KING. I also want to thank you, Mr. Gelfand. Remember us to your boss when you go back home, those of us from New York.

Let me ask you one question now: Do you recommend civil commitment or this commitment that you speak of, prior to conviction and without a criminal conviction?

In other words, would you favor giving them the choice of being civilly committed.

Mr. GELFAND. Yes. I do recommend that, Mr. King, as is provided in the bill, and I do so for this reason: Most of these addicts would rather serve a 6-month sentence than go through a program such as this. They have to be offered some inducement to submit themselves to the program and, therefore, the bills wisely embody the inducement that if one will commit himself to the program and will abide by its requirements, including aftercare requirement, that by so doing for the total 5-year period, he can avoid the stigma of the criminal conviction and the penal punishment.

Mr. KING. He and his counsel, I assume, have to consent to this in New York, do they, under your statute?

Mr. GELFAND. Yes; they do.

In that respect, under Congressman Gilbert and Congressman Celler's bills, they provide for a procedure similar to the New York procedure.

Mr. SHATTUCK. Has this been tested in the court proceeding; has it been tested as to whether this satisfies due process; and does it take care of the demand and right of a speedy trial?

Mr. GELFAND. No question has arisen as to due process and right to

a speedy trial because right to speedy trial would only arise where an act of the prosecution or the sovereign prevents a speedy trial.

Under the New York program any delay in the trial is occasioned by the voluntary acts of the defendant in order to have the benefit of the program and he cannot complain of that any more than he can complain of delaying his trial due to an adjournment that he requested.

Mr. KING. Suppose he says, "I wasn't mentally competent to sign the consent. I was an addict. I had the shakes. I would have done anything to get a shot in the arm."

What would you do with that case?

Mr. GELFAND. The bills provide for a 10-day period before there is a determination, so an addict cannot explain, "I was dragged off the street with the shakes, signed this, and the next thing I knew I was committed for 5 years."

We are constantly faced with that problem in every facility of law enforcement. At many times after the event he says, "At the time I confessed I was incompetent. At the time I pled guilty I was incompetent."

This is not a problem unique to this situation, but characteristic of every procedure involving a criminal defendant.

Mr. KING. This is a little bit different. This fellow is a dope addict.

Mr. ASHMORE. Is it possible that he could be incompetent? This is unique, it seems.

Mr. GELFAND. The competence of most addicts is affected only at the time they are subject to either withdrawal or in a state of intoxication from narcotics. Their general competence is probably as high or higher than the general run of criminal defendants.

Mr. KING. You have found that from your experience.

Mr. GELFAND. That is probably the greatest evil of this whole addiction: that it reaches into the areas of many people who could be otherwise worthwhile and productive citizens were it not for their addiction. And tragically we find situations where people are occupying the highest positions, which are highly remunerative, and yet they become the victims of addiction.

Sometimes the extent of habit of $100 and $200 a day, and one of the reasons why these people do not hit the public view to such a great extent is that, being in higher economic areas, they are capable of obtaining their narcotics without the exposure to apprehension that some of the less fortunate victims economically are exposed to.

They don't have to go out on the street corner in order to buy narcotics.

Mr. KING. Who is excluded under the New York State statute?

Mr. GELFAND. Under the New York State statute there is a specific exclusion of anyone who has committed a crime punishable by death or life imprisonment which would encompass murder and kidnaping.

Mr. KING. That is all?

Mr. GELFAND. No; there are further exclusions.

Anyone who has two prior felony convictions is absolutely excluded.

Anyone who has previously passed through the program is excluded. Obviously that person didn't benefit once and it would be foolish to place him through it a second time.

Finally, anyone whom the prosecution does not consent to enter the program is excluded. That broad discretion I consider necessary since addiction is so widespread among those committing crimes, and a program such as this cannot be universally applied.

Mr. KING. Does the court also have to consent to that?

Mr. GELFAND. Yes; the court also has discretion.

Mr. KING. The court has the discretion to deny the right to the defendant, even with the district attorney's consent.

Mr. GELFAND. That is right, Mr. King.

A further exclusion which is of the utmost importance which I failed to mention is that it must be certified to the court that there is a facility available to accept the defendant before he is placed in the program.

Mr. KING. Has he any physical examination by any doctor to determine whether or not in the doctor's opinion this would be beneficial?

Mr. GELFAND. Yes; he is subjected to the same preliminary examination as provided in Federal bills and, of course, without that preliminary examination it would be foolish to apply the program.

Mr. ASHMORE. In New York the law does not provide that the defendant sign a plea of guilty before he accepts or is given this civil commitment?

Mr. GELFAND. No; he does not. There is no action at all on the criminal charge.

Mr. ASHMORE. The law in California regarding narcotics does require that, does it not?

Mr. GELFAND. I am not familiar with the California law, Mr. Chairman.

Mr. ASHMORE. You think he should not be required to plead guilty; is that correct?

Mr. GELFAND. Yes.

Mr. ASHMORE. I mean just enter the plea and, of course, further prosecution under the plea is stayed or withheld until he is released from the institution or until his civil commitment is terminated one way or the other.

I don't mean you can go ahead and prosecute him. I understand in California, if he successfully goes through with it, the plea is wiped out and there is no criminal record held against him. Have you had an opportunity to compare the California law in that regard to the New York?

Mr. GELFAND. I have not compared it, but the reason I would favor his not being first convicted is I think that the charge is a greater hold over the defendant than the ultimate conviction, since in most cases, particularly in the crowded urban areas where the problem is the greatest, most criminal charges are disposed of by lesser pleas and once the defendant is aware of how he is going to come out criminally, he may feel this is a better deal than entering the civil program.

Mr. ASHMORE. The Government or prosecution is put at a disadvantage. You may have no witnesses or your evidence might have disappeared by the time he is committed and released and the time you have to try him.

Mr. GELFAND. The delay, Mr. Chairman, would be no greater than present delay in criminal prosecution due to the volume of crime in urban areas.

Mr. McCLORY. I thank you for your statement, Mr. Gelfand. I don't know whether I understood correctly or not the item on the period during which the election must be made.

In one case it must be made within 5 days after the first appearance before the court, and in Mr. Celler's bill within 10 days. He has at least 15 days or 10 days and also he has a maximum of 5 or 10 days to make this election.

Mr. GELFAND. As I understand it, that is the election by the defendants who apply for the program but it is not within that period that it is determined whether or not he will be admitted to the program.

Mr. McCLORY. Then the Surgeon General or the Attorney General will determine whether or not he is qualified for the program.

Mr. GELFAND. That is correct, Mr. McClory.

Mr. McCLORY. You really haven't had enough time elapse in the State of New York to determine from experience whether or not the New York program is valid or is not valid, effective or not effective, have you?

Mr. GELFAND. In my personal view, I would say we have not, but I would also like to say with the utmost emphasis that the problem is increasing on such a level that we cannot wait for further tests of the program such as the New York program before some aggressive action is taken in this field, and that unless we do embark upon aggressive pilot programs, the problem is just getting further and further away from us since it is a multiplying effect.

The more old addicts you have this year, the more new addicts you are going to have next year and the longer we take before we attempt to stem this tide, the more addicted individuals we are going to have to deal with.

If some program is not adopted in 1965, the problem of 1966 will be so much greater than the problem is today, just as the problem today is many times greater than it was last year and the year before and the year before that.

Mr. McCLORY. Are you asking us to adopt any program no matter whether it is effective or not, or aren't you, instead, asking us to adopt some kind of an effective program and the basis for it is that it has been tried or tested or proven in some way?

Mr. GELFAND. I would say that at this point I certainly am not asking for the adoption of any program just for the sake of saying a program is adopted.

I have indicated, unless a program is adequate, whatever is placed into the program is wasted. At this point there is no guaranteed program and the only way we are going to find out if a program is effective is by testing it in the hard crucible of experience.

I submit that the program proposed by Congressman Celler and Congressman Gilbert represents a program that offers the greatest hope and a program that on its face represents a much more reasonable chance of success and if we are going to wait for the guaranteed program we are going to wait until it is much too late.

Mr. McCLORY. These programs are patterned after the New York program?

Mr. GELFAND. Yes. I would certainly say the New York program cannot be classified as unsuccessful or a failure. My only criticism

of the New York program is that it has not been applied to a greater level and this is true because of a lack of funds.

Mr. McCLORY. Isn't it true also that we haven't had enough time elapse to determine its efficacy?

It hasn't been in effect long enough, has it?

Mr. GELFAND. I would say a true determination of efficacy would probably take 20 years since we would have to trace the pattern of an addict through the balance of his life, but the program has had an impact on those to whom it has been applied.

As I pointed out, the danger of waiting far overbalances the risk of further gambling on such a program.

Mr. McCLORY. Stiff penalties have had a salutary effect, have they not, with regard to the prosecution of narcotics offenders?

Mr. GELFAND. Stiff penalties have a great salutary effect when they reach those primarily responsible for the distribution of narcotics. Tragically in the areas where the greatest number of addicts are congregated, in the urban areas, reaching the narcotics seller whom we hold in the greatest disdain, is a rare and difficult occurrence, since there is such a strata of users through whom he can distribute his narcotics that the overwhelming bulk of arrests of violators of the narcotics laws involve individuals who could be more truly classified as victims than perpetrators.

Mr. McCLORY. Well, stiffer penalties have been a definite deterrent though, haven't they, in your experience, in Chicago and Detroit?

Mr. GELFAND. There is no question about that, Congressman. I would like to state that I am strongly in favor of the stiffest penalties in these areas, but I think it is unrealistic to believe that we can take 100,000 or 200,000 or 300,000 addicts and lock them all up for 20-year sentences and solve the problem that way.

Mr. McCLORY. No; our real difficulty here is to distinguish between the sick narcotic addict who is not a criminal and the criminal peddler or seller of narcotics products, is that correct?

Mr. GELFAND. Yes, Congressman.

Mr. McCLORY. And it is a difficult distinction to make, isn't it, in the prosecution or administration of justice?

Mr. GELFAND. No; it is not a difficult distinction to make in individual cases. With regard to individual defendants, it is quite clear whether he is the person whom we would call the criminal or he is the person we would call the victim of a vicious system.

With reference to the stiff penalties, as we have stiffened the penalties through the years, we have witnessed addiction not decreasing, but increasing. So that in itself is not the sole solution and we must now try to approach this by drying up the purchaser as well as destroying the seller.

Mr. McCLORY. I would question that last statement that the imposition of stiffer penalties has not resulted in reduction. At least it has reduced the increase.

Mr. GELFAND. There is no question it has reduced the increase, but left us still with an increase. We cannot say that we are making great inroads into the problems of narcotic addiction at this point.

It is a problem which offers an ever-greater threat to the community life we strive for in every area.

Mr. ASHMORE. We will now hear from Robert F. Walsh, assistant district attorney, Brooklyn, N.Y.

STATEMENT OF ROBERT F. WALSH, ASSISTANT DISTRICT ATTORNEY, BROOKLYN, N.Y.

Mr. WALSH. Thank you, Mr. Chairman.

Mr. ASHMORE. I would assume your testimony is along the lines of Mr. Gelfand's. We also want to get to the doctor, who might be able to answer some of the questions we have.

Could you give us a résumé of your statement or you can read your statement.

Mr. WALSH. I have a short statement, Mr. Chairman. My position is a little different in that I am in charge of the narcotics bureau in Kings County.

I appreciate the opportunity to appear here in behalf of the district attorney, Mr. Aaron E. Koota, and to discuss the bills proposed by the Congress.

As stated by the previous speaker, 52 percent of the narcotics addicts reside in the city of New York.

We, in reading the bills, feel that H.R. 9167 is similar in a lot of detail to our article IX in the mental hygiene law in New York State. We do feel that it is lacking in that there is no enabling legislation.

The lack of adequate funds to carry out the provisions of article IX is the biggest problem that started with the program and remains with it.

There was a program set up and no funds to implement it.

The enabling legislation was cut off as it is in 9167. There is no enabling legislation to facilitate the program.

We feel that the provisions of H.R. 9051 which provide a program of Federal grants which would authorize the appropriation of $14 million annually for 3 fiscal years to assist the States in the construction of facilities for treatment of drug abusers should be incorporated into the administration bill, H.R. 9167.

The hospital facilities are needed. The aftercare clinics must be constructed and adequately staffed in the communities where the addict lives and is returned to after his release from confinement.

Most of all, the halfway houses program should be largely expanded and financed. It is our position that the eligible addict, when he is sincere, be allowed to seek civil commitment and be treated medically. The addict cannot be left to himself to cure his habit. Experience has shown that 95 out of every 100 addicts revert back to the use of drugs. The treatment has to be compulsory. The addict needs to have his morale strengthened. He should be taught a trade, helped in obtaining a position upon release from the hospital, and he must be examined and followed to prevent a relapse.

But we should not, however, in our drive to help the narcotic addict, forget that we also owe a larger duty to the law-abiding, nonaddicted population of our country. It is their interests that we should always keep in mind when we prepare any legislation. Drug addiction is both a health and a law enforcement program.

Safeguards are needed to prevent the narcotic seller and smuggler from using the new legislation to escape his just punishment.

H.R. 9167 provides that the individual be examined by the Public Health Service to determine if he is in fact an addict. It also provides that he not be bailed out before or after he applies for civil commitment.

This bill is preferable to the other bills in that it applies to Federal crimes other than narcotics and it is our experience that the addict commits forgeries, larcenies, and other nonviolent crimes to support his habit. This type violator should also be considered for treatment.

In the New York bill we have a limit. If there is a misdemeanor and he remains on the program, after a year his case is so dismissed. If there is a felony after 3 years, his case is dismissed.

Mr. KING. Regardless of the felony?

Mr. WALSH. Regardless of the felony.

Mr. ASHMORE. That is after the man has been civilly committed?

Mr. WALSH. That is right.

The provision of the law relating to holding the criminal charge in abeyance should, however, state a time limit; that the charge shall be discharged at the expiration of 3 years if the individual successfully completes the treatment program including both institutional treatment and aftercare in the community.

The administration bill is preferable in that it excludes anyone who is charged with a crime of violence, anyone who has two or more previous felony convictions and anyone who has been civilly committed for narcotic addiction on two or more occasions.

We feel that these are safeguards owed the general nonaddicted public and should be made part of any legislation passed in this field.

The New York bill, incidentally, is broken down. The first part deals with the narcotic offenders. Then we have another section that deals with the nonnarcotic offenders. The exclusions are similar, but absolutely different in the two.

The exclusions are as follows:

That he has been convicted on two or more prior occasions of a felony.

He has been civilly committed under this act because of his narcotic addiction on three or more prior occasions arising out of three separate arrests.

The facilities are not sufficient.

It is not in the interests of justice to commit the defendant civilly.

He has been previously convicted of a capital crime, or he is presently charged with a felony for which a mandatory minimum term would have to be imposed on sentence were he to be convicted and committed.

Were he to be convicted of and committed for the felony for which he is presently charged, he would have to be sentenced to serve at least a statutory minimum term because of the prior felony conviction.

The district attorney does not consent to civilly committing the defendant and holding the crimes charged in abeyance subject to the ultimate dismissal as provided in the act.

These are the exclusions under the nonnarcotic crimes.

Under the narcotic crimes, the exclusions are that—

there is pending against him a prior felony which has not been determined; he has been convicted on two or more occasions of a felony.

He has come under the act because of narcotic addiction on three or more prior occasions.

The amount of drugs alleged in the charge pending against the defendant is substantially greater than would be necessary to support the defendant's own narcotic habit.

Mr. KING. For how long?

Mr. WALSH. For how long?

Mr. KING. Support his habit for how long? One day, two days, three days, a week?

Mr. WALSH. We would feel that a quantity—a felony possession quantity in the average addict would be something that falls in this

category. We would feel that the average addict would not have on hand that quantity. This is the feeling of the district attorney.

We feel that these statutes dealing with sale and smuggling should remain strict. The mandatory penalties have helped to curb the illicit traffic in narcotics.

The limitation on the man who is charged with selling narcotics provides that the defendant is not eligible for commitment unless he convinces the court that the sale was made to support his addiction. We feel this is an advance over the New York law which excludes all sellers.

We heartily approve of the new legislation if properly financed and a good program of aftercare for addicts after release from confinement, is created.

As a further safeguard—the exclusion we feel should be added that the possession of drugs substantially greater than would be necessary to support the defendant's own narcotic habit also be included in this present legislation.

In New York State anybody who sells narcotics is excluded from the program. We feel that in some cases a user-seller should be included in the program so we are in favor of that portion that is not in the New York State.

Mr. KING. You fellows can determine that in your own office and by your own investigation and exercise your own good justment as to whether a user-pusher is really a pusher or whether he is doing it for his own habit.

Mr. WALSH. I wouldn't like to speak for the other counties, but I know in my own office we maintain a file on each individual narcotic. We know pretty well who are pushers and who are not pushers.

Incidentally, I would like to say presently in New York City and for the last 5 months there has been quite a shortage of heroin and I think this is due largely to the efforts of the Federal Narcotic Bureau and the police department in the city of New York which is doing an excellent job in going after the higher up importers.

At the present time the addict is paying $15 for a bag of heroin that he used to pay $5 for.

Mr. ASHMORE. How many shots are in that?

Mr. WALSH. A $5 bag is one shot.

Mr. ASHMORE. One shot?

Mr. WALSH. One shot.

Mr. ASHMORE. Just for general information, how long will a shot last a man? How many does he need in a 24-hour period?

Mr. WALSH. I think if you ask Dr. Baird, who is an expert in this field, it would be better.

Incidentally, I think Dr. Baird has an excellent program and I am sure he will speak about that.

We had 439 applications in 1964 for this treatment.

Mr. ASHMORE. Under this legislation?

Mr. WALSH. Yes; 189 were denied.

The reason for most of the denials was that there were not sufficient beds available. We had proposed legislation to take over Ellis Island and turn that into a rehabilitation center but this has since gone by the board but we strongly feel that a facility such as Governor's Island might be utilized for a thousand or 2,500 addicts, that they could

be detoxified, sent to the island and taught a trade, maintain the island themselves and eventually be sent off into the community and come back.

The control of the addict could be done by the chromatography which is the urinalysis of the addict on a daily basis, which would show if he is using narcotics.

If he is using narcotics, he would be sent back then to the hospital for further psychiatric and medical treatment. This is a program that we follow in Day-Top Lodge in our probation department in Staten Island.

There is a new program of Day-Top Village where this program is pursued. At Day-Top Lodge we have certain—in the program is limited to 25 members. We have some who go to high school and come back and live in the house.

We have one boy I think who went to college. We have two or three who go into the city to work and come back and live in the house. This has proved fairly successful.

We are in favor of a medical care program. We are in favor of halfway houses. We are in favor of control on the individual.

We think if he is put on probation and they have clinics set up in the neighborhood where you can examine him always on a weekly or biweekly basis, and it is determined that he is using narcotics, then you send him back either to a hospital or to jail.

If he remains free of the use of narcotics, that he be allowed to be put on probation. We feel this would be an answer, not a complete answer, but an answer.

The addict must be trained, he must be shown a new way of life, he must be given some kind of a future. Otherwise we feel that the program is a waste.

Incidentally, I might say that the cost on the Ellis Island figures was approximately $4 a patient for 2,500 patients. Now, this is not quite a large sum of money and we feel that the money provided for in Mr. Celler's bill, 9051, would be adequate to pursue alternate-type programs.

Dr. Baird's program is an approach that should be tried. Some of the other approaches also should be tried. I think the Day-Top Village in Staten Island, which is an offshoot of our probation program, ought to be financially assisted and programs of this type supported.

Mr. ASHMORE. Do you mean $4 a day to maintain them in the institution?

Mr. WALSH. Yes.

Mr. ASHMORE. You state one of these islands or places or institutions that you now have could be converted into a hospital or facility to take care of these people and treat them, up to 2,500. Do you mean you anticipate the treatment of 2,500 in the State of New York?

Mr. WALSH. We have much more than that.

Mr. ASHMORE. How many do you have?

Mr. WALSH. In New York City we have approximately 50,000 addicts in the city, yes.

I don't think that the figures of the Federal Bureau—I think that they state 25. I think we can conservatively say 50,000 and probably a hundred thousand would be a better estimate. That is New York City.

Mr. McCLORY. In New York State the Federal Bureau records 29,063 active narcotic addicts.

Mr. WALSH. I would feel 100,000 would be closer.

Mr. HUNGATE. I would like to compliment you on your presentation.

Could you give us any idea why the difference would occur in those figures between what the Federal Bureau would have and what——

Mr. WALSH. There is an estimate that for every known addict there are three unknown addicts. The figures of the Federal Bureau only are reported figures. People who have been arrested, people who have been reported by the doctors. Now, there is that hidden group that haven't been accounted for.

Incidentally, I think it might not be a bad idea for the Federal Government, with the States, to establish a program of reporting the addicts. I think there should be some program of that type.

Mr. HUNGATE. There is no method——

Mr. WALSH. There is no present method that would record the number of addicts other than the official records that the Federal Bureau takes from the arrest records.

Mr. HUNGATE. Automobile thefts, would that be recorded? Would your cooperative system include automobile thefts?

Mr. WALSH. Yes.

Mr. GILBERT. They have a national association on automobiles. I believe the insurance companies have that.

Mr. WALSH. I think there should be something along the lines of the National Bureau to count narcotic addicts.

Mr. HUNGATE. You mentioned the time for treatment. Under your law, how long can you sentence them to this treatment?

Mr. WALSH. They are not sentenced. Our program goes in this manner: The man applies for civil commitment. He is then examined by two doctors who certify him to be an addict. He is then sent to one of our hospitals and he remains in the hospital anywhere from 4 to 6 months and he receives psychiatric treatment and detoxification, if he needs it.

Then he is sent out into the neighborhood and is followed up on an aftercare basis. If there is a misdemeanor after a year, then the case is dismissed.

Mr. HUNGATE. What is the maximum length of time that you can keep him under this civil commitment arrangement?

Mr. WALSH. Misdemeanor is usually a year and a felony is 3 years.

Mr. HUNGATE. When he volunteers for this program he must remain under it if it is a misdemeanor for a year or a felony 3 years, unless the authorities would release him sooner; is that correct?

Mr. WALSH. Well, no, he would still be under their control for that year. It is only after the year that his case would be dismissed.

Mr. HUNGATE. In the case of a felony, if you should find him cured sooner than that, would they release him before 3 years?

Mr. WALSH. No, his case would not be dismissed until after the 3 years.

Mr. HUNGATE. Have you had any occasions where—you don't take a plea of guilty here. He applies for civil commitment?

Mr. WALSH. That is right.

Mr. HUNGATE. And the charges are still pending. Let us suppose it is a felony and after 2 years you can do nothing with him or at the

end of the 3 years he is not cured. What has been your experience then on the prosecution?

Mr. WALSH. We have had no difficulties with prosecuting. In fact, we have had about 60 to 70 who either fell off the program or started using narcotics again.

Just last month we had what I consider an unforturate case. Here is a fellow who was followed up by the probation department. His father got him a job in Connecticut. He did not get permission from the head of the probation department to move to Connecticut so they told him to come back and unfortunately this fellow did not come back. He would lose his job if he came back, so they picked him up and they reinstituted the prosecution of the felony against him. We spoke to the judge and we gave him a misdemeanor plea because here is a fellow apparently who had proved successful under the program and I don't think we should have prosecuted him.

Mr. HUNGATE. In other words, he had violated but not in the sense of falling into his old habits?

Mr. WALSH. That is right. He violated the rules of the probation department and that was the situation there.

Mr. HUNGATE. I understand California's law requires them to plead guilty and then if they are properly rehabilitated the record is expunged of the crime. You say your system has worked very well?

Mr. WALSH. Apparently our system—as I say, it is brand new. As you see by our figures, half of the people who apply are not accepted because there aren't the facilities to pursue it. You don't know. What are you doing with the other half? Perhaps in there is a 40 percent better chance of completing the program.

I think we ought to be given an opportunity or the doctors ought to be given an opportunity to examine and pursue each and every individual who would want to go through the program.

Mr. HUNGATE. Did I understand if there is a prior felony charge pending they are not eligible for this?

Mr. WALSH. That is right.

Mr. HUNGATE. Regardless of the record or whether it is just pending?

Mr. WALSH. Yes. If it is pending, he is not eligible. You see, he could have applied at the time——

Mr. HUNGATE. Thank you, Mr. Chairman.

Mr. GILBERT. Mr. Walsh, first, I congratulate you for your testimony here this morning. It has been enlightening to the committee.

There is one aspect I want to go into a little bit and that is the aftercare treatment. I think you were here when I alluded to it with Assistant District Attorney Gelfand.

In your experience in the field, which is extensive, do you find that the State of New York has made adequate provision for aftercare treatment?

Mr. WALSH. No. No; they haven't put the money into the program that is necessary to facilitate the aftercare program. The money isn't there and the facilities are not available.

Mr. GILBERT. Well, then, based upon all the testimony that you gave, with your example of this one boy who was removed from his environment and, of course, had an opportunity to get away from his old habits—all this money would be poured down the drain if this

boy would return back to his old stamping grounds and he would revert right back to where he started?

Mr. WALSH. We don't feel that. We feel if you set up in the area clinics and that the individual must go to the clinic and be asked that he will stay off the narcotics because he knows that the test is going to show positive and if it shows positive he will go to jail.

Now, I think Chicago had worked this out and had been fairly successful with about 500 addicts, if I am not mistaken, in the poorer neighborhood of Chicago, and it developed that the addict knew he had a choice. He could live in his community if he is off narcotics. If he started to use it, then he went to jail. Knowing this and knowing that he cannot beat the test, he has stayed off the use of narcotics.

Mr. GILBERT. I agree that would be a step in the right direction. However, a couple of weeks ago I read about a voluntary program, I think over at Princeton University, where addicts voluntarily submitted themselves to some sort of a program they were instituting at Princeton University and yet within a day or two they broke into the narcotics section there and they stole all the narcotics and they all wound up in jail.

I don't know, you see, if you keep them all together, that that is the answer.

Mr. WALSH. You see in a voluntary program, there is nothing hanging over his head. There is the problem.

If he is not involuntary, he knows he is going away to jail for another 5 or 10 years and this is the deterrent. The voluntary patient relapses a good amount of the time. I think the Lexington figures prove less than 2 or 3 percent who stay off narcotics. We feel the deterrent is the time facing him in jail.

Mr. ASHMORE. Thank you very much. Our next witness is Dr. Robert W. Baird, of New York City, N.Y. He will give us some testimony on the medical side. Doctor, will you proceed as expeditiously as you can?

STATEMENT OF DR. ROBERT W. BAIRD, DIRECTOR OF HAVEN CLINIC, NEW YORK CITY, N.Y.

Dr. BAIRD. Thank you very much for the privilege of appearing here. I hope I can create a little more confusion among your thinking along medical lines.

I, as a practicing physician, have one more theory to be discussed which I hope will not be confusing, but which can graphically demonstrate a new approach. I humbly submit these arguments with all due respect to my more experienced and older medical colleagues.

With an office in Harlem, and admittedly with the limited experience of 12 years, I have observed narcotic addiction from the street level. I have learned the hard way from hundreds upon hundreds of addicts because when I went to medical school there was no formal institutional training on drug addiction. From these individuals I have learned, painfully, the story of addiction—how opium and heroin and marihuana get to the United States; the various ways they get on the street; the various avenues of getting illicit moneys; the various combinations of drugs and the various ways to beat the authorities and to con doctors out of narcotics. After having seen a 9-year-old

youngster on narcotics, I realized that I, as a physician, should make a concerted effort in my area to come up with some program to help eradicate some of this problem.

Out of this evolved the clinic which I conduct called the HAVEN Clinic, which means help addicts voluntarily end narcotics, which is supported solely by myself. The clinic operates from 10 p.m. to 4 a.m., from Monday through Friday, and when necessary on Saturdays and Sundays. We have a little higher success rate than normal because the motivations with many of the addicts is greater. They voluntarily seek aid and they want to give up the habit—not want to want to give it up. Those people who want to want to give up the habit are those still out on the streets. I have realized the small facilities I have are not sufficient and have initiated a campaign to see if funds can be raised for a narcotics hospital in New York City with outpatient clinics throughout the five boroughs which would operate free and on a 24-hour basis. And these facilities should be strictly for drug addicts, not a wing on a general hospital where the addicts are looked upon as the scum and riffraff of our society.

Mr. ASHMORE. Doctor, I hate to interrupt you, but the Surgeon General of the United States, at an earlier date, testified that we have facilities throughout the country in various States where these people could be put and treated; meaning institutions not solely for this purpose but State hospitals and the like.

Dr. BAIRD. Except in New York; I do not think we have those facilities. The facilities one does have to send these drug addicts to, like Kentucky and Fort Worth, are completely removed. You must have facilities in the endemic area. Kentucky does a wonderful job but it is so far removed from the environs where the youngster has been brought up that there is not enough aftercare.

Mr. ASHMORE. I think it is admitted they do not have the proper aftercare in those institutions. You feel, I gather from your statement, that you need an institution to treat these people for drug addiction and this alone?

Dr. BAIRD. Right.

Mr. ASHMORE. And that they should not be put in a mental institution or some other institution, but should be in an institution which treats this alone?

Dr. BAIRD. Right, so you can have specialists.

Drug addiction does not work on the hours of 9 to 5, nor are there any holidays like Christmas or New Years. Every hour, every day, the drug addict needs help more than any other type of patient. The outline of our goals is as follows:

(1) To procure a hospital in which to place drug addicts for a period of detoxification using other drugs rather than narcotics, except in the few recalcitrant cases and to have ambulatory narcotics clinics not using narcotics for withdrawal. During this hospital stay they should receive intensive counseling and psychotherapy. This is an area where we in the medical field have fallen short. In the 60 years of treating drug addiction, we in the medical profession continually revert back to the theory that if we are to treat them, we must treat them with more narcotics. There is enough medicine you can give to stop convulsions and to stop the individual from continuing to lose weight. But we in the medical field have developed a disease which I call "paralysis by

analysis." We have this fantastic new research program where they saturate them to 200 milligrams. To give you an example, if we were treating a cancer case we might give 10 milligrams three times a day to stop the pain, and here they saturate them to 200 milligrams. And they have been going outside saying they are functioning well and people outside shoot them with dextrine and they drink whisky and alcohol. So we still have an addicted personality, whether an alcoholic or a narcotic addict. So I have asked them why they must use the methadone. The youngsters have had this drug available on the street for 20 years, and have been procuring it on the street, and have been using it, and all of a sudden we have a breakthrough, supposedly, of the so-called methadone. In a short while you will find 75 percent of these youngsters and adults are back again on drugs.

Mr. ASHMORE. Barbiturates and other things, do they drop back on those?

Dr. BAIRD. Barbiturates, of course, is a different type of habit. Even with the excellent police force, narcotics are still available in the street; we have the dope available, but it is reduced so much that the quantity is not enough for the youngsters to get the full reaction. So you add barbiturates to it to prolong the effect of the heroin. If you add barbiturates to heroin, which also induces sleep, it prolongs the effect of the heroin.

(2) After the period of detoxification in the hospital, to get the cooperation of unions, school systems, and others to help teach and train these men and women to some vocation such as plasterers, carpenters, secretaries—practical application of job interest. This should be a time of not sitting in the hospital watching television, playing checkers, and making ceramics all day, because this just potentiates their pleasure-seeking mechanisms of no responsibility. Rather than sitting in the hospital playing tiddlywinks and going to little dances, let this time of 6 months or a year be used constructively.

(3) After this period of training, 6 to 8 months, during which time they are still at this hospital in an informal setup, not wearing pajamas and bathrobes—do not let them wear pajamas, because if you do they will think they are sick, and they will develop sloppy habits. They would then be allowed an afternoon or evening out, then to return to the hospital at night, gradually giving them more and more liberties after they have proven themselves.

(4) If this period of 1-day-a-week has been successful, allow them a weekend at home so that the temptation to take drugs could be overcome and the transition made easier.

(5) During this time, if training has been successful, or if they already have a vocation, we would then procure a job for them. We would try to get the cooperation of industry and the big department stores to help hire them. At the end of the day they would return to the hospital. The idea would be to gradually get them to have confidence in themselves and be able to withstand the temptations of the community.

(6) Clinics would be established throughout the various communities on a 24-hour basis, open at night so that an addict, if he should suddenly develop a compulsive craving or desire to return to the use of narcotics, he could talk it over with someone and in this way help to get over the rough period. These should not be 9-to-5 clinics.

Addicts do not take drugs or develop problems on a 9-to-5 basis. A youngster calls me up at 6 o'clock in the morning telling me he is going out of his mind.

Mr. ASHMORE. Doctor, you use the word "youngster" so much I would like to ask whom you are including?

Dr. BAIRD. Anyone between 17 and 68.

Mr. ASHMORE. Seventeen and what?

Dr. BAIRD. Seventeen to 68, but most are under 30 years old. So that you tell a boy to come on over and perhaps that stopped his compulsion to take off. We only saved him 1 day, but he is still clean.

Then another thing we have to evaluate is the hospital personnel. Personnel for these clinics would be recruited from the mother hospital and would attend weekly meetings so that rapport would be established with the narcotic addicts who would be going to the various community clinics. This would preclude the possibility of the addict feeling that he is going to a strange therapist, or group of people who really do not know the problem. It is so important to individualize therapy with drug addicts.

It would be a great thing if some of the hospitals in New York would have their personnel equated. I hate to see lesbians and homosexuals in hospitals. One of the youngsters told me, "Doc, it is tough to go straight because you have those queers around." I said, "How do you know they are queers?" And he said, "Because when they walk they wiggle and when they laugh they giggle."

When I mentioned that to a doctor he said, "Well, you have to rehabilitate homosexuals." "Yes," I said, "but you should not treat them with narcotic addicts."

(7) To employ hospital personnel who are dynamic and driving and whose appearance and demeanor are smart, bright, and alert so that the addict can look up to these people as leaders and make some identification. Drug addicts are keenly perceptive to those therapists and those people who are helping them and many of them have commented on the apathy and lack of interest and careless dress of those who should be the epitome of hope and inspiration.

(8) To further research in the fields of drugs and the causes for taking them and to encourage training in medical schools, nursing schools, and all other schools associated with narcotics problems.

(9) To disseminate the education of narcotics and its ramifications to all concerned—public schools, churches, philanthropic organizations, parent groups, and so forth, by competent lecturers. The adverse reactions of narcotics must be vilified and not glorified. This has been a grave mistake in education. We have to go in the schools in the 9th or 10th grade where they start with airplane glue and educate them as to the dangers. Too many people glamorize narcotics. If they would only tell the kids, "If you get arrested and get a felony conviction you will lose the right to vote, and if you want to get a job at Macy's you have to be bonded, and if you want to drive a truck you cannot get a license." You have to give them the cold facts and not glamorize it.

Mr. GILBERT. Who glamorizes it?

Dr. BAIRD. You have no doubt read of the so-called high they get where they have a complete escape and hear music better.

Mr. GILBERT. I have read it, but that is the point, is it reporting of the newspapers, magazine articles, medical journals?

Dr. BAIRD. I wish there were more in the medical journals, that would be fine, but a lot of it is in the newspapers and, after all, you educators read the newspapers and they pick up something. We have a professor in one of the universities in New York who says marihuana is all right, it increases their perception. If you feed this hogwash to the students—and I try to tell them of the dangers—they say their prof said it was all right and that makes it very difficult. But of course this chap talking about it has done a great job of reading an article in the New Yorker and he is an expert.

(10) Treatment must be free because otherwise we would encourage them to go out and rob and steal. They also develop a moral responsibility when they know people are devoting time and effort to them.

We are attempting to accomplish the following legislative ends:

(1) Make illegal any cough medicine preparations containing codeine or any derivatives of opium unless prescribed by a doctor. None of these should be sold over the counter without a doctor's prescription. In New York City there is a group of pharmacists who have heard about HAVEN's work and voluntarily refuse to sell any cough preparations containing codeine unless accompanied by a prescription. They say that this is their small contribution which they offer to help HAVEN's efforts.

There is an idea that once a man is 21 years of age he has a divine inspiration not to buy narcotics. I have a man in the process of dying who consumed 22 bottles of ETH with codeine, 88 ounces of alcohol and 88 grains of codeine, but if this were under a doctor's prescription, he could not get that much.

(2) Impose economic sanctions on countries to whom we give foreign aid (green stuff) and who in turn send us illicit exports of heroin (white stuff). They would then make an attempt to maintain better narcotics traffic control.

(3) Legislation to the effect that all diplomatic personnel have baggage inspected by dual inspectors, at the country of his origin, or his embassy, plus our customs officials.

(4) Levy a fine against the mode of transportation (ships, planes) in which the narcotics come, as well as a fine against unions who vouch for said individuals. This would further more thorough screening of all personnel by employers and unions.

(5) Inspection of all personnel, commercial and armed services, coming in and out of our country for possible heroin addiction. This means a physical as well as a property examination. I suggested this once to a Senator and I was told it was too hot, but I will bring it up. There are a lot of our youngsters in the armed services who are in endemic areas like Thailand and Japan who come back with pure heroin and they are not checked out. One boy was sending pure heroin in our country and another fellow overseas could not get it so the fellow who could get it bought a box of cherry cordials, took the cherries out of the chocolate, put heroin in them, replaced the cherries in the chocolate in the candy box and sent it out as a gift to the one overseas, and he got his box of candy, heroin and all.

(6) Revocation of driver's licenses of addicts involved in automobile accidents, in addition to examinations for drug addiction of all individuals involved in accidents. Many of the States do not have this, particularly in New York. They do not bother to check out,

if there is an automobile accident, whether the guy involved has been on narcotics. We take away his license if he is on alcohol, but narcotics is even worse because if he is intoxicated you can see his unsteady gait, but you cannot detect it if he is on narcotics. Then he goes to sleep and has an accident.

(7) Another thing we would like to have is unannounced physical examinations of all elementary, high school and college students three times a year—in September, after the Christmas recess, and just before school vacations in June. This is particularly necessary in the endemic areas where drug addiction has developed or is now running rampant. This is extremely important because there are so many cases where individuals have been on drugs 2 or 3 years before either school officials or families have known that they are on drugs.

You have a problem here because you have boys and girls who drop out, ostensibly because they do not get along in school, but actually a lot of them are hooked on drugs and if we could get hold of them earlier we could reach them psychologically.

(8) A part of hygiene courses from the sixth grade on should incorporate the explanation of the advanced reactions of glue sniffing, heroin, goof balls, and pep pills, to let the youngsters actually know how very sick they can get on these medications, including the possibility of death never make it bizarre or glamorous, but factual and sobering.

(9) Development and building of a narcotics hospital in New York City solely for drug addicts, with rehabilitation centers open 24 hours a day, with inpatient living facilities, under the charge of dynamic, knowledgeable personnel which is a must, together with on-the-job training and job procurement and incorporating HAVEN's program as outlined in its brochure.

(10) Restoration of cabaret licenses and chauffeur licenses of drug addicts who have been convicted of narcotics charges, with the provision that they have been medically certified off drugs by a narcotics specialist for 1 year. They should be kept on probation for a period of 10 years, during which time their licenses should be renewed every 3 months. This will allow those who are dependent on a specialized vocation to work productively. If they have been clean a year, let them have their driver's license or cabaret license. If you have a chap who has been playing a musical instrument and he cannot get a license and has to be a porter, he cannot cross that bridge.

(11) Revocation of the licenses of pharmacists who sell narcotics, cough preparations, derivatives of opium and other synthetic addicting drugs, barbiturates, and amphetamines without a prescription. The penalty should be the same as for the professional heroin pusher, 50 years. We have pharmacists who will give a kid seconal, and I think this pharmacist is far more guilty than a pusher on the street.

(12) The penalty for the nonaddict pusher should be 50 years without probation or parole. As a safeguard against those who would plead that they are addicts, urine analyses and blood tests should be given with careful observation for withdrawal symptoms over a period of 10 days.

This is one I always ask for and I get hit across the head for it. You have to give the nonaddict pusher 50 years without probation or parole. I have an office in Harlem and many of the Mighty Mo ball-

players have been my patients. The fellow I say "Good morning" to every day on the street behind my back is Mr. Big.

I had one fellow sent away for 7 to 15 years and I asked him about it and he said he got apprehended for pushing narcotics. In the daytime he was a milk wagon driver. He said, "I make $1,800 a day pushing narcotics. They will send me away for 7 years. When I come out I have $1.5 million waiting for me. If they put me in jail for the rest of my life or give me the electric chair, that would do something, but with good behavior I will be out in 5 years."

We have these laws on the books but they are never utilized to the maximum. I think if we strengthened them in New York you would have a great drying up of the problem, but a lot of people say you must psychologically rehabilitate them.

To illustrate the irony of this, I had one boy 19 years old who was on heroin. His father was a bookie. His father came to me and said, "If I ever find the man who hooked him, I will kill him." I came here to appear before a Senate committee and while I am looking at pictures of pushers, here is the father of that boy. So the law of justice caught him and his own son is addicted.

(13) Any commercial operation, whether retail or wholesale which sells or gives airplane glue or its derivatives illicitly to suspected users should be given 25 years. Anyone buying the item should be required to produce a certified form of identification such as a driver's license or a draft card, or if a minor, accompanied by a parent or someone with the required identification, which must be written in a book and an account of all sales must be kept. Anyone with fraudulent identification should also get a penalty of 25 years.

We have a problem in New York with airplane glue. A chap in the Middle West, in Iowa, 19 years old, died from airplane glue. I think if it is going to be sold it has to be sold by an adult to an adult with the adult producing his driver's license or draft card for identification. Too many people in the United States will buy this stuff and give it to a youngster. There is one youngster 16 years of age who takes 10 tubes a day. That is an awful lot.

Mr. ASHMORE. They inhale that stuff?

Dr. BAIRD. There are several ways. He either puts it in a handkerchief and it looks like he is blowing his nose, or they might take a plastic bag and tie it and squeeze it and they pass out and die because of asphyxia. This boy was getting 21 tubes a day from a store, and the irony is after the chap at the store gives it to him he gives him a paper bag and says, "This is on the house." A chap like this, that owns the store, I would put him away for 25 years. To me he is a pusher.

(14) The illicit manufacturer of barbiturates, amphetamines, and cough preparations which have been flooding the black market should be classified in the same category as the professional drug pusher and, further, receive a 50-year sentence. All pills should have a lot number and manufacturer's name and code. They have bottles of amphetamines which are liquid and there is no name on them and the kids pay $1.25 for it and to manufacture it costs about 10 cents. These are the black markets that have come up. Within a couple years you will find we are deluged with this. I am happy to be a private practicing physician because when you are close to the ground you can hear the grass growing and you have to get the vibrations from the youngsters in the street.

In regard to the proposed legislation, H.R. 9167 and S. 2114, I have the following recommendations:

(1) In the treatment of drug addiction, any decrease in the penalties for trafficking of drugs would lead to utter chaos. It is the strong deterrent of jail that has caused so many addicts to keep their habits down because of not wanting to be apprehended with more than a certain amount of cigarettes of marihuana, or more than a certain amount of heroin. As soon as the Government sanctions a decrease in the penalty, the drug addict will immediately feel that the Government does not think it a major offense. These youngsters are real Philadelphia lawyers. They know what is a felony and what is a misdemeanor. They have a very high IQ and have too much time on their hands which is not constructively employed.

(2) All minimum mandatory sentences should actually be increased and should not be subject to decrease by a judge. Suspension of sentencing and placing violators on probation is not the answer to a problem that has been growing more and more rampant.

(3) In defining what makes a buyer, it should be set down that the quantity an individual can carry when apprehended should not be more than one cigarette of marihuana, or more than one bag of heroin (which should weigh no more than 120 milligrams and should be less than 5 percent pure). If he is apprehended with more than one of these items then he is to be labeled a pusher-addict and should be sentenced to a prison psychiatric ward for a minimum of 6 years. Such action would follow a prior conviction and hospitalization. Four years should be spent in the prison psychiatric ward and 2 years on parole in a narcotic hospital. The reason for this is as follows:

(*a*) This will keep the drug addict's habit down.

(*b*) It would cause him the inconvenience of having to go out to get those extra bags and would act as a deterrent because he would be afraid of being apprehended by the police more often.

(*c*) It would prevent a regular pusher from just having a bag of pure heroin on him which he could dispense by a tooth pick to the drug addicts on the street.

If a drug addict has been on a rehabilitation program and is apprehended with narcotics on him, he goes to the hospital for a mandatory sentence of 1 year, and then if released and he reverts again to selling, he would go to the psychiatric division of the prison and after a period of good behavior he would be eligible for parole after 2 years, which means that he then goes to a narcotic hospital to receive the rest of his sentence under intensive psychotherapy and job training and job procurement. This constitutes a minimum of 3 years. If failure after this time, he is to be remanded to the psychiatric division of the prison for a minimum of 10 years. This may sound cruel, but it must always be borne in mind that a drug addict is an infective and effective vector of a communicable disease.

As was brought out this morning, if we are going to think they are mentally sick, how in God's name can we give them the right to make the decision whether they will be hospital-committed or go to jail? These kids are too smart. If they think they can evade going to jail, they will do so. So what you have to say is, "You are mentally sick." Do not give him 10 days because in 10 days he can kick the habit. As soon as he is apprehended he should be sent to the hospital for treat-

ment because he is mentally ill and is not in a position to make the decision at that time. It takes a drug addict approximately 16 to 17 years of sick thinking to arrive at this point and we in the medical profession think in 3 or 4 months we will undo this thing.

These kids are smart and when they come for the fourth time around they feel they have a lot going for them. He will say, "I was born in the ghetto; my father is dead; I have to make a living for the family" and so forth. You have to have a firm attitude and say, "You have to be treated."

You must remember that every drug addict you have is responsible for four or five other devotees. And this is an important thing. As Assistant District Attorney Walsh said, I believe there are over 100,000 addicts in New York City. The Bureau has only the reported ones. But you have one drug addict who supports three or four.

I just came back from England and while there I saw one woman addict who was getting 500 pills a week. She was keeping four young girls on her dope, but she was reported as one addict. She was an old crony of 52 keeping four young girls in their teens on her dope.

Another point that must be considered is that a drug addict must always be kept under surveillance and after parole is completed he should be kept on civil probation for 10 years as I have described before. Have the probation officer make a spot check once a week. Do not make it every Tuesday because he will goof off until 3 days before he goes to the probation officer and he will say, "I am clean."

Time served in a hospital does not count toward punitive institutional custodianship since this would give him many more advantages. Any patient would prefer going to a hospital with all of its social activities and less regimented form of existence than a prison would allow. The addict must be ready to assume the responsibility for his own treatment and face the rewards of success and the punishment of failure.

Any sale of drugs must be a mandatory offense whether the recipient of the sale be 18 or younger. This is something I feel very strongly about. It has to go right across the board. Is one's life less dear at 19 or 35 than at 18 or 16? Chronologic age is not an index of the maturity of an individual past the age of 14. If anything, selling to an addict with an adult's economic responsibilities is financially more of a loss and burden to the community than an adolescent going to school.

In conclusion, I want to say that drug addicts can be helped if the motivation is there. If the motivation is not there, an attempt to instill it should be made by personnel who are inspirational. It must always be remembered that it has taken a drug addict approximately 20 years of sick thinking to become what he is, and we, in the professions, should not think that 3 or 4 weeks of psychotherapy will undo this pathological reflex way of thinking. Such a short span of time will not accomplish this. It takes concentrated effort of several years, but the addict can be helped and cured. Do not legalize or attempt to treat drug addicts on an ambulatory basis with synthetic narcotics, such as the methadone debacle, which has been hailed as a major breakthrough, but is actually a major breakdown, because not only will the addict be psychologically crippled, but he will also lose the motivation and the desire to give up drugs.

It is my own personal conviction that never has so much been written or discussed by so many who know so little about a subject as big as narcotics addiction.

Mr. ASHMORE. Thank you for your wonderful statement, Doctor. May I ask, if it is not too personal, is your institution supported by some foundation?

Dr. BAIRD. No. My pocket.

Mr. ASHMORE. You do not get any pay for treating these people?

Dr. BAIRD. No. This is all free. If I were to charge a drug addict for treatment I would be negligent because in order to pay my fee he would have to go push narcotics. And if you work the hours I do, from 10 p.m. to 4 a.m., they see that you are working those hours to help them and it gives them a little pride and restores their ego. It does not rehabilitate them. Rehabilitation means you had something real great to begin with. Here you never had anything real great to start with. You have a kid who has inherited a psychological impoverishment from his own parents. They can tell which of us are really motivated in wanting to help them. An 18-year-old Puerto Rican said to me that he went to a psychiatrist, a typical one with beard and rough tweed coat, all the masculine bit, and the psychiatrist said to him, "What is your problem?" And Puerto Rican kid said, "Doc, if I knew what my problem was I wouldn't be here."

In order to be able to put this across to people you must have institutions with the right type of personnel. You have to do it 1 day at a time.

Mr. ASHMORE. Most of them are innately weak?

Dr. BAIRD. All of them are innately weak. They do not have discipline.

Mr. ASHMORE. You have to give them the desire to get away from this?

Dr. BAIRD. Yes. Unless you do that, and unless you have the personnel—and a narcotics addict looks for two things: mental prowess and physical prowess. You know how many in my own profession are sweet chaps; they never caught a baseball. You have to be able to talk the game and this is the only way you are going to get success. I just read an article about a fantastic woman who treats these drug addicts. It sounds great. But let me tell you, no boy will go to a woman psychiatrist and say, "You know what I have been doing?" There is this distance between them. But if he goes to a man, one that swings with him, he can do something.

These kids get together before they go to see a psychiatrist and they decide they will tell the psychiatrist they came from a broken home; that they hate their mother. They feed the psychiatrist everything they have read in the books and there it is. That is why this is such a tough fight.

Mr. ASHMORE. I wish we had more doctors like you and we would have less of an uphill fight. I would like to question you but we have a quorum call.

Mr. MCCLORY. Do we need a program for psychiatrists?

Mr. GILBERT. I am just curious, Doctor. Do you think group therapy is of any help?

Dr. BAIRD. Yes. There are three ways. The first is individual therapy where you see the individual alone. The second is where you

bring in the mother and father or the husband or wife. The third is society therapy, and we get those that are clean to get up and talk on why they are clean. They are getting pride in themselves and they themselves are talking to other drug addicts that are still on narcotics. So you have three things going for you. You can remember as a young boy when you were asked to give a talk off your hat, there would be this trepidation, but then you build up confidence so that you can go before the Congress and make a fantastic speech. These kids are withdrawn and they are communicating with a doctor, with their parents, and with a group of people. So don't just keep them with a head shrinker, a psychiatrist, all the time. I am not a psychiatrist. I am an endocrinologist. This is not to be relegated to the field of mental hygiene or psychiatry. Whoever is dynamic and knowledgeable, we should correlate all these external forces so we can lick this problem.

Mr. ASHMORE. Thank you very much, Dr. Baird. I am sorry we do not have more time to hear your views and to ask you questions. Thank you very much for appearing before us.

(Thereupon, at 12:15 p.m., the subcommittee adjourned.)

BILLS PROVIDING FOR CIVIL COMMITMENT AND TREATMENT OF NARCOTIC ADDICTS

FRIDAY, AUGUST 6, 1965

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE NO. 2 OF THE
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10 o'clock in room 2141, Rayburn House Office Building, Hon. Robert T. Ashmore (chairman of the subcommittee) presiding.

Mr. ASHMORE. The committee will come to order.

We shall resume our hearings on the narcotics bills.

Today we have Dr. Henry Brill, consultant in narcotics addiction to the New York State Department of Mental Hygiene, and also he is director of Pilgrim State Hospital, in West Brentwood, N.Y.

STATEMENT OF HENRY BRILL, M.D., CONSULTANT IN NARCOTICS ADDICTION TO THE NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE, AND DIRECTOR OF PILGRIM STATE HOSPITAL, WEST BRENTWOOD, N.Y.

Mr. ASHMORE. Doctor, we are glad to have you with us. We are glad that you can come to us and give us the benefit of your experience in this important area. We shall be glad to hear from you at this time.

You may read your statement or give a résumé of it or talk to us in any way you desire. We shall interrupt for questions as you go along, if you do not mind; or, if you prefer, we will wait until the end of your presentation.

Dr. BRILL. I do not mind being interrupted at all. You do as you wish about that.

I will not read the statement, but I will give you a résumé of it.

Mr. ASHMORE. Proceed, Doctor.

Dr. BRILL. Mr. Chairman and members of the committee, this is a welcome opportunity to testify regarding certain proposed narcotic legislation which you have before you. In the statement I have taken the trouble to point out that there has been a great deal of advance in this field since 1958 when the New York State Department of Mental Hygiene first became interested in treating narcotic addicts. We had long recognized it was a medical problem, but practical implementation of this point of view had not been possible because of lack of facilities.

It happened at that time that, because of the beginning decrease of mental hospital populations, space became available in hospitals for

treatment, and we began reviewing the scientific literature and we began consulting with others, and we finally developed a program for the treatment of addicts. This began in September 1959 with a 55-bed treatment unit at the Manhattan State Hospital. After that, using that unit as a training center, we were able to develop six specialized installations in mental hospitals for the treatment of narcotic addicts and, in addition, an aftercare service for following these addicts after they left the hospital.

At the same time, a basic science research institution was created at a cost of about $1,700,000 at Manhattan State Hospital, because it was felt that there was not enough information, that there was a great lack of information in the field of narcotic addiction. There was a lack of information as to the basic facts, the underlying principles involved, and there also was a serious lack of practical information as to the best treatment methods and the indications for using these treatments.

In the course of our clinical operations we developed enough data to warrant the passage of the Metcalf-Volker law, which represents a codification of the various techniques, the various legal aspects, of the treatment of narcotic addiction. This Metcalf-Volker law includes a provision for voluntary admission of patients. It also includes a provision of civil certification of nonarrested addicts. a certification very much like that of the mental hospital patient, and a civil certification of arrested drug addicts.

This has now been in operation since January 1, 1963. We have processed several thousand cases through the system which is set up.

One point which is specified in this law which might be worth noting is that when the addict is in a detention facility and before provision has been made for him to go for treatment, while he is still under arrest, he should have consideration for humane detoxification. While the man is under arrest and awaiting trial, waiting to make up his mind whether he wants to go to a treatment facility or whether he wants to take a chance of going to jail, he should have, I think, the right to a humane withdrawal.

Mr. ASHMORE. How long does that take, Doctor?

Dr. BRILL. The average withdrawal will be 10 days or 2 weeks. In some cases, if there are barbiturates involved, it may take a little longer. You will note this is well within the usual time of observation and legal procedure.

Mr. ASHMORE. One of the bills we have under consideration provides for a 5-day period, and some of the other bills a 10-day period, before the defendant is required to make an election whether or not he will voluntarily accept civil commitment. Do you think 5 days are sufficient for a man to get in such mental condition or sufficiently removed from the influence of narcotics so he would be able to say whether or not he wishes to accept civil remedy?

Dr. BRILL. I think he should be in a mental condition to be able to make a valid decision.

Mr. ASHMORE. Within 5 days?

Dr. BRILL. I think so. The mental condition of the addict is not marked by special clouding. He is mentally reasonably clear. The thing that one has to be concerned about is that within 24 hours after he is arrested he needs additional drugs, and some cognizance should

be taken of this need. As long as his withdrawal is humane and he has a gradually decreasing schedule of medication, there is no reason that his mental condition should be disturbed or his judgment should be impaired.

We have not encountered any trouble on the basis of a man's being in acute withdrawal and being so upset that he cannot make a valid decision in the operation of our law.

May I continue?

Mr. ASHMORE. Please.

Dr. BRILL. Experience with the operation of our law makes clear that this type of procedure, that is, having an arrested drug addict in facilities for treatment, is practical, sound, and constructive. It provides for a humane and valuable service to patients, and it creates a mechanism for the orderly development of new knowledge in the field of narcotic addiction. This new knowledge fills a universally recognized need.

More recently, the State administration has announced a considerable increase of the budget for narcotics, and has provided for contractual agreements with established community groups operating halfway houses, sheltered workshops, and various community services to addicts. This, it is hoped, will fill out our program very effectively. I think this is an important addition to the program, bringing community groups in to work with the addict after release from the hospital.

The comment which follows is based on our experience in New York, although the results of various site visits elsewhere play an important role at several points.

There are several points in the Federal proposals which I might point out.

Judging from our work, it would seem that a broad definition of eligibility would be worthwhile considering, and that it would not be necessary to limit such eligibility to narcotic offenders alone. The Metcalf-Volker law has such a broader orientation for those who elect to be considered, and this has not been a source of difficulty. Exclusion of commercial peddlers is, of course, a necessary provision, and it would also seem that those who are charged with serious crimes of violence should be excluded. Primarily, acceptance for treatment would seem to be based on the question of whether the individual is suitable for the program which is available. If he is suitable, I think it important that every effort should be made to get him in. This suitability can be based on somewhat more global, somewhat broader principles than trying to decide in advance what kind of offense will make him eligible and suitable and what kind of offense will not.

Under H.R. 9167, this determination rests with the Surgeon General, who sends his recommendation to the court and the successful case is not returned to court following the institutional phase of treatment. This to me would seem preferable, rather than having the man return to court prior to the commencement of aftercare. If his treatment is proceeding in satisfactory fashion, it would seem that he might well be returned directly.

Opportunity for narcotic addicts to enter a rehabilitative program after conviction also seems to be an excellent provision. We have had some experience with this sort of thing, and we find that such addicts

do respond well. We have had them come to us when they have been released on parole under condition that they come for treatment in a hospital, and they do well.

The main new principle which this type of legislation introduces is combining the influence of the law enforcement agency with that of a medical treatment group to produce a treatment situation for a narcotic addict. Combining the authority of the law enforcement with the techniques of the psychiatric organization seems to be an important principle.

The development of an adequate aftercare program is universally accepted as very important, and its inclusion in the legislative proposals appears fully justified.

The development of a program of Federal aid in connection with inpatient services and aftercare services is another very important step forward, and it is strongly urged that such support be considered on a matching basis for all ongoing, well organized and established programs of treatment for narcotic addiction.

A complete delineation of the various responsibilities of different levels of government in this field of narcotic addiction appears to be much indicated so there will be a clear statement of the responsibilities of each level of government in this field.

Turning to another subject, in the New York area we have seen a very encouraging increase in the number of agencies which are active in the treatment of narcotic addiction and, concomitant with that, an increase in the number of people who are personally experienced in the field. With the growth of this group, we are developing an increase in the area of consensus of professional opinion as to how we should best approach this problem. I think in past years there has been a tremendous diversity which undoubtedly is confusing to anyone who is trying to reconcile these various points of view. I am quite encouraged by the fact that during the last year or so there has been a tendency toward development of a consensus.

For example, the question of maintenance therapy for addicts. At one time there were some who recommended that maintenance should be given orally, and that this would be a solution to the problem.

Mr. ASHMORE. What sort of maintenance, Doctor? Do you mean for him to live on?

Dr. BRILL. No. I mean providing drugs for the addict to maintain himself in his addiction. Heroin was proposed at one time, morphine perhaps. Methadone is the drug which now has been suggested.

Incidentally, methadone is an opiate, and it is very much like heroin and morphine. It has less addictive value, but it still has a very strong addictive value and it is still an addictive drug.

Mr. SHATTUCK. It is a dangerous drug, is it not?

Dr. BRILL. Yes, very definitely.

Mr. SHATTUCK. Can you buy it over the counter, or is a prescription required?

Dr. BRILL. It takes the same type of prescription that morphine takes because it belongs to the same family.

Mr. SHATTUCK. Therefore, it falls within the definition of a narcotic drug within the law.

Dr. BRILL. Yes, absolutely.

Mr. SHATTUCK. As we understand, Doctor, you have lived in England and studied English methods. I am sure if you would enlighten us on any point of their experience, it would be appreciated.

Mr. ASHMORE. Will you tell us a little about your experience with the English method?

Dr. BRILL. I approach this question later in the statement.

In New York there has been a great deal of thought about the possibility of using Methodon across-the-board for maintaining addicts, taking the profit out of the narcotics traffic and stopping the spread of narcotic addiction.

The consensus of opinion now is narrowing down very sharply. Even those who are most active in recommending the trial of maintenance therapy speak of less than 10 percent of all addicts as eligible for this kind of treatment. Most people think of 1 or 2 percent or perhaps less than that as eligible for trial.

As you know, there are some experimental projects which are now being undertaken in the New York area to test out to see actually how many people can be maintained in a satisfactory state with such maintenance techniques, how large the dosage, and what methods may be used. No responsible medical authority in the New York area today speaks of an across-the-board maintenance program for all addicts. This is a great advance in the past few years.

Mr. ASHMORE. What do you mean, Doctor? Do you mean one has to be treated in one manner, and another one in another manner?

Dr. BRILL. It is generally recognized by experienced people in this field that giving drugs to the average addict can only result in further difficulties for him.

Mr. ASHMORE. In other words, you do not agree with the British system?

Dr. BRILL. I do not agree with what has been called the British system. I may say we began our contact with the British system in 1958 when we visited England, and we found there was no British system. The British had about 350 known addicts. Most of them were medical addicts. They were older people, and they were receiving medication for chronic disability, chronic pain, and they were in no physical condition to have the drug withdrawn. Because they had such a very excellent situation, they did not require any strict rules or regulations, and their regulation in theory permitted a physician to prescribe narcotics if he felt that it was indicated. The regulations were so drawn that if you looked at them one way you might consider he could even maintain an addict; if you looked at them another way, you might consider he was not allowed to maintain an addict.

The fact was that a few addicts were being maintained. This was accepted and was tolerated.

Since that time, the situation has changed rapidly. I was there with Dr. Larimore last week.

Mr. ASHMORE. You mean it has changed in England?

Dr. BRILL. In England, yes, sir. Whereas during our last visit they had only 60 known heroin addicts—out of all the 350, only 60 were taking heroin—today they know of 300 heroin addicts, and there very likely is a considerably larger number that they do not know about. The total number for a country of the size of England is still not large, but this represents a fivefold increase.

Furthermore, the heroin has now reached a young, gregarious group of individuals who get supplies from physicians and sell them among themselves and propagate the habit. It appears very likely from what we were able to gather that the British will now be forced to do two things. One is to set up a treatment unit or two treatment units in the London area, and the other is to establish some sort of restrictive procedure which will control the spread while it is still at a controllable level.

There is some concern and a good deal of concern and discussion in the British press, both the professional and lay press, on this subject.

Mr. HUTCHINSON. If you would permit a further interjection here, I think I saw in the Washington papers a day or two ago that there seems to be a great increase of addiction at one of the universities in England, and that a former Prime Minister's grandson recently died from it.

Dr. BRILL. I did not have any direct information and I was not able to get any during our trip, except to confirm the fact of the death and that this undoubtedly drew further attention to the problem.

It is interesting that as far as the British authorities have been able to determine, this habit has not been confined to the poverty-stricken classes. It is not limited to the slum areas. Apparently it has reached some of the lower middle-class groups and has caused rather widespread concern. It involves people of many different social classes.

Mr. ASHMORE. You may proceed, Doctor.

Dr. BRILL. To go just a little bit further with respect to the British system, it appears that the original story was based on the British experience in the Far East. There were very large numbers of people there addicted to opium and later to hard drugs. Large populations had to be withdrawn. In the Far East in the colonies, the British did set up a registration and did allow legal issue of drugs at minimal cost to addicts. But this was limited to the colonies. They never did have a registration of the home country, and they never did have a legal issue. What they had, as I mentioned before, was a few doctors and a few addicts and a tolerated situation which could be tolerated while it was small, and which probably now will not be tolerated much longer.

A new report is due on this subject very shortly from the committee which is reporting to the Government there.

Support for research as proposed in H.R. 9051 is highly important and would have implications well beyond the field of opiate addiction since there is good reason to believe that drug abuse generally represents essentially a branch of psychopharmacology; that is, the study of the effect of drugs on the psychic life. Of course, we use drugs very extensively in mental illness.

The study of psychopharmacology is one aspect of psychiatry, and, of course, addiction is one corner of that entire field. The rest of it is the constructive type of psychopharmacology and the use of drugs for the treatment of mental illness. It is to be hoped that investigation and research in the field of drug addiction will make its contribution to an understanding of mental disorder generally as well as to an understanding of the various kinds of addiction and habituation.

The interaction of psychiatric disorder with drugs is a question of utmost public health importance.

In this connection, one of the important pieces of research which remains to be done has to do with the scientific evaluation of treatment results. At the present time it is extremely difficult to make meaningful comparisons between statistics taken at one location with statistics taken at another location because drug addiction varies with the type of drug used, the environmental situation, and the type of person involved.

For example, physicians who have become addicted to drugs have a remarkably good remission rate. It runs 50 to 75 or 85 percent under treatment. This is very different from the rate of remission or the rate of being clean or recovery that one finds in the street addict. The rates depend very much upon the type of person involved. They depend also very much on the type of drug involved and the intensity of the involvement. An individual who is not physically dependent, who has a shot of morphine or heroin once in a while, represents a very different problem than the individual who takes 3, 4, 5, 6, or more grains of heroin a day.

So, comparative statistics from one place to another are meaningless unless one is sure that he is comparing exactly the same kinds of patients. One can get statistics which vary all the way from 50- or 75-percent cure in one group to a 5-percent cure in another group. This may be traceable not at all to differences in technique, but to differences in type or selection of cases.

Mr. HUTCHINSON. May I interrupt a minute here, Doctor? You are talking about different types of addicts and pointing out that each group of addicts may be an altogether different kind of case. I suppose you would agree that the addicts who would be picked up under this proposed legislation would be addicts who are not charged with crime and would be, for the most part, the so-called street addicts, would they not?

Dr. BRILL. I think they would be. I think very likely these would be the more difficult cases; yes.

Mr. HUTCHINSON. So our problem of percentage of actual cure would be more difficult. The group that we would be dealing with under this law would be the group where you would not expect to have a very large percentage of cures, is that correct?

Dr. BRILL. There is this possible variation: An individual who is picked up for an offense may have a concomitant addiction which is mild. That is, he may take a shot once in a while. He may not represent as serious a problem as a man who never has been arrested, necessarily, but who is addicted to a heavy, steady usage of the drug. So, the fact that he is an arrested individual may make him difficult to handle in general, but it does not necessarily prove that he is heavily addicted to a narcotic. He may be a user rather than a severe addict. This would be reflected in the rate of cure of the addiction.

You helped me clarify a point that is described in my statement—the necessity for control and the necessity for determining what is the spontaneous remission rate, spontaneous rate of cure in any group of addicts, because there is a spontaneous rate of cure. The mildly involved individual has a much higher rate.

Incidentally, another important fact is that the older addict is fre-

quently a better candidate for treatment than the young individual. If the young individual is fully involved, he may be a very difficult person to treat.

Mr. ASHMORE. Why is it that the older person can be cured easier than the younger? Do you know?

Dr. BRILL. Nobody knows, but there is an interesting parallel between the rates of cure of addiction and the rates of cure of criminal behavior generally. As people get older, the tendency to antisocial behavior diminishes. Perhaps the tensions, the fires within the individual are banked down a little bit, as it has been expressed. This fact makes him a better prospect for cure.

Mr. ASHMORE. Maybe I put the wrong interpretation on your statement. You are talking of a person older in years, rather than a person who has been on the drug a longer time.

Dr. BRILL. Yes. I did not state that right.

Mr. ASHMORE. I thought you meant the man who had been on it longer was easier, but you mean older in terms of years.

Dr. BRILL. After 35, after 40, the rates of remission rise quite definitely. Under the age of 25, the rates of remission are lower.

Mr. SHATTUCK. Doctor, in the administration bill there is a provision permitting the utilization of certain procedures for youthful offenders. In the testimony presented to us previously, it was indicated youthful offenders may give better promise of rehabilitation. This seems to run somewhat counter to what you have just said. I realize it is a difficult question and perhaps unfair, but have you any comment?

Dr. BRILL. If I remember correctly, the youthful offender law goes to age 26.

Mr. SHATTUCK. That is correct.

Dr. BRILL. Our most difficult cases are the heavily involved boys 16, 17, 18, up to 20. If they are fully addicted, they tend to be very difficult to treat. While this is true, that should not stop one from trying to treat them. In the middle twenties one may expect better results.

I still would hold to the fact that age being the one fact, all other things kept constant, as age advances the statistics will improve.

Mr. SHATTUCK. Thank you very much. As we discuss this, we do not want to give the impression that we would not treat the younger offender, but perhaps, should this legislation become law, a judge might infer that the youthful offender somehow or other should be given a preference, whereas the older man brought in for a Federal offense which is not excludable under any exclusion, might well be a good subject for rehabilitation, and this should be considered.

Dr. BRILL. I think that is right. It would have to be decided on an individual basis. Of course, a youthful user, not a heavy addict but a youthful user, may represent a very good case for rehabilitation. There are so many other factors to be taken into consideration that the total picture would have to be drawn before one could comment on the prognosis.

Mr. SHATTUCK. Thank you very much, Doctor.

Mr. HOFFMANN. Doctor, I have a question which comes up on the difference between a user of an addictive drug, an addict who might be addicted to an addictive drug, and the user of a nonaddictive drug, such as the user of marihuana. A two-part question:

First, would you comment generally on your views on marihuana and whether we ought to soften our treatment of marihuana offenders?

Second, could you comment on the relationship of the nonaddictive drug to a psychological addiction based on comments the marihuana user does not need rehabilitation because he is not addicted?

Dr. BRILL. Marihuana, unfortunately, has been very closely linked with heroin. It tends to be a first step or second step toward the use of heroin. I think it needs to be kept under control, very definitely. Even though there is no physical addiction to marihuana, it does have, as you pointed out, a psychological addiction.

When I spoke of the user, I had in mind the heroin user. There are people who have taken heroin from time to time but who are not physically dependent on it. I was contrasting the outlook for the heroin user as compared with the heroin addict who was physically dependent.

Mr. HOFFMANN. But you still talk about cure and rehabilitation with regard to the user.

Dr. BRILL. Yes.

Mr. HOFFMANN. That implies to me that this man may have a problem which would seem to be psychiatric.

Dr. BRILL. It is psychiatric, but the problem is psychiatric in all these addictions, very importantly psychiatric, although there are social aspects to the problem and there are even correctional aspects. Yes; I believe the basic problem is still psychiatric.

Mr. HOFFMANN. So, actually a marihuana user might well present the same problem that a heroin user does from the point of view of psychiatric rehabilitation.

Dr. BRILL. You have the same problem, and in some ways it would be just as difficult; but because there is no physical dependence involved, the ability to stay clean when he leaves the institution would be much higher and, as a result, the statistics would be expected to be much better. I would expect to have much better statistics from a group of marihuana users than from a group of heroin addicts.

Mr. HOFFMANN. How about the heroin user?

Dr. BRILL. The heroin user, again, requires rehabilitation and is a problem, but his statistics would be better than those of a heroin addict.

Mr. HOFFMANN. How would they compare in statistics to the marihuana user?

Dr. BRILL. I think they probably would fall between the heroin addict and the marihuana user. It is more serious than marihuana, but not as serious as full addiction.

Mr. HOFFMANN. You would recommend giving consideration and treatment of the marihuana offender on psychological dependence on marihuana?

Dr. BRILL. If the facilities were available, yes: and I think they should be made available.

Mr. ASHMORE. While the marihuana user is not an addict, he is in such position psychologically, and otherwise probably, that he could easily become an addict, could he not, by using heroin and morphine rather than marihuana?

Dr. BRILL. Yes.

Mr. ASHMORE. If he continues down the road, he will end up as an addict, very likely.

Dr. BRILL. And he is in contact with the kind of people who take heroin. He is in contact with a market that somehow carries both in close proximity.

Mr. ASHMORE. Is not the same thing true of the user of barbiturates, to a lesser degree?

Dr. BRILL. With certain users of barbiturates; yes. There are many people who take a sleeping pill to go to sleep and who are never in contact with an illicit market; but once the young person comes in contact with a group of drug abusers and with the heroin market, then the same principle comes into play.

Mr. HUTCHINSON. Doctor, you stated that the marihuana user had advanced to the second step. What is the first step?

Dr. BRILL. Probably the so-called goof balls, that is, barbiturates and amphetamines. I would not want to be too emphatic about making this a stepwise affair. Some people begin by experimenting with marihuana and move on to heroin, but many of them also begin with the drugs that are even more easily available.

Mr. HOFFMANN. I do not want to throw a red herring in, but how about LSD?

Mr. ASHMORE. What is LSD? I am not familiar with that. I am not as familiar with some of these terms as he seems to be. He has been prosecuting in the District of Columbia and has a good bit of experience with these people.

Dr. BRILL. LSD is a scientifically very interesting substance which was discovered about 15 years ago. It derives from an early fungus. In unbelievably tiny amounts it can produce hallucinations. It produced an acute state which at one time was considered to be a model psychosis. People who are addictive in their psychology found that this is an interesting substance to take, and especially on the west coast they have gotten supplies and have experimented with it, and there has been a good deal of writing about this drug and the idea that this opens the door to a higher level of perception.

While this is a potential drug abuse and there are many others like it, in numbers the LSD users are relatively few. In certain places it belongs in the constellation of drugs of abuse.

Mr. ASHMORE. Is it easily obtainable?

Dr. BRILL. No, sir. It is even more difficult to get than most others. The supply is quite restricted.

Mr. ASHMORE. You may proceed.

Dr. BRILL. If I may continue, I should like to summarize by stressing the following points, again basing my conclusions on our New York State experience.

Civil commitment or civil certification of narcotics offenders is desirable, and their medical treatment and rehabilitation is a practical undertaking which can be expected to produce steadily improving results as techniques are further developed.

I would like to stress that we are far from being as far as we want to be. There is much to be done and much new information to be gathered. This is now in the process of development.

Federal aid for programs and for construction will be of very great value in speeding the development already underway under various auspices.

Research at the basic level and at the clinical level as well as evaluation studies and epidemiological investigations are of great importance if we are not to be misled by easy optimism on the one hand, or unwarranted pessimism on the other.

It is easy to find statistics which will indicate that you might expect a 50-percent remission rate as a result of a given technique, and it is easy to find other statistics which indicate that once an addict, always an addict. I think the truth lies very definitely between these two extremes, depending on what kind of cases one treats and what kind of techniques are brought to bear. I think statistics definitely will be improved as we go along and improve our methods.

Narcotic addiction tends to be a chronic relapsing disorder. It is the manifestation of an underlying psychiatric disorder, and in addition creates new problems all its own. Advance in this field can be expected if we are willing and able to apply the same techniques and tactics which have led to therapeutic advance in other medical areas, if we are willing to use the same skill, patience, and single mindedness.

If I may, I would like to stress the word "patience," because this calls for patience. I do not think we have a total answer to this problem promised to us in the immediate future, but I think we are getting there and the progress is very promising.

Mr. ASHMORE. You are definitely of the opinion, Doctor, that more research is necessary?

Dr. BRILL. Yes; I am.

Mr. ASHMORE. Is the regular bill going to give us enough money? Do you have an idea as to how much money should be used, the amount which you think is necessary in the field of research?

Dr. BRILL. I would be hard put to give you a meaningful figure. I do not remember a specific figure from the bills. If several million dollars could be made available at this time it would be a good start.

Mr. ASHMORE. 9051, section 10, states:

> For the purpose of financially assisting the several States in the construction of facilities for the treatment and rehabilitation of drug abusers, there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the 2 succeeding fiscal years, the sum of $15 million.

That is for facilities.

Then there is section 19 of the same bill:

> For the purpose of financially assisting the several States in establishing, developing, and maintaining treatment of rehabilitation services for drug abusers there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the 2 succeeding fiscal years, the sum of $7,500,000.

Dr. BRILL. Yes, sir.

Mr. ASHMORE. Would that be an appropriate sum, do you think, Doctor? Have you given enough study to that particular phase of it, the research phase of it, so that you would have figures in mind?

Dr. BRILL. With respect to research I think several million dollars available, say $4 million available for research, would be an important start, $3 or $4 million.

Mr. ASHMORE. Per year, for the next fiscal year?

Dr. BRILL. For the next fiscal year, and from then on the operating experience would determine what level could actually be used.

Mr. ASHMORE. One of the bills provides the sum of $15 million.

There has been testimony that we need additional facilities, and then on the other hand we have had testimony, I think from the Surgeon General, and perhaps other Government agencies and departments, that there are enough facilities now to take care of these people if we put them in State institutions and mental hospitals. They do not say that the two Federal facilities provide adequate facilities, but by using existing State facilities and private institutions some think we do not need any additional hospitals.

What is your opinion?

Dr. BRILL. The average State hospital would have to have additional funds to make its facilities suitable for the treatment of narcotic addicts. One cannot take the average addict, or take an addict, and treatment in an average State hospital facility.

The funds that are made available could be used for rehabilitation and for improvement of these facilities to handle narcotic addicts.

Unfortunately, while there are State hospital beds available, not all States have facilities—well, let me rephrase that. Many of these are obsolete or obsolescent. I think one would have to look at the local situation.

My impression is that construction funds could be effectively used in the New York area.

Mr. ASHMORE. We had a doctor yesterday, an expert in this field as you are, Doctor, who gave some fine testimony in my opinion, and he stated that in his opinion it was not best to use the open hospital but one to treat these people and do nothing else. On other words, that would be the primary objective of the institution, not a psychiatric institution or a mental institution but one just for this sort of treatment. What do you think?

Dr. BRILL. I think that you need a special unit with special personnel, but this can be in a larger psychiatric hospital. It can be one of the specialized units such as hospitals now have a special unit for child psychiatry and a special unit for geriatric psychiatry.

One could have a large specialized unit for nothing but drug addiction.

Mr. ASHMORE. This doctor was of the opinion that it had not proved successful in his experience to have these patients coming into contact with other mental patients, or other patients, those other than narcotic addicts.

Dr. BRILL. I would agree they should not come in contact but for a slightly different reason. I think they need to be kept from contamination with drugs, and the average open hospital ward today does not protect the patient from contact from the outside. A narcotic addict is easily contaminated under those circumstances. There is too easy a contact with people from the outside who would bring him substances. I have seen this attempt made and I think I would agree that the mental hospital ward is not the place for treating the narcotic addict mixed with other patients.

Mr. ASHMORE. I would like you to comment a little more—do you agree that the aftercare program is of vital importance after these people are off the drug?

Dr. BRILL. Treatment without aftercare is generally considered to be inadequate. It is generally considered that one should support the patient for a considerable period after he leaves the institution.

There is some controversy as to how long—1 year, 2 years, 3 years. I must admit if you were to ask scientific information of me, real scientific data, I would have to say we don't have it yet. Hopefully we will have it as the result of the experience we have had.

Mr. ASHMORE. It will be the result of more research, I suppose.

Dr. BRILL. Yes, sir.

Mr. ASHMORE. In this aftercare period what has your experience been insofar as contacts with probation officers are concerned? Should they report back to the hospital every so often? Should these probation officers visit them? What is the best remedy?

Dr. BRILL. Probably best to have them visit an office or a clinic not far from where they live. This would be the main point of contact, a clinic.

In addition the social workers or the probation officers will wish to make home visits, also, to contact the family and visit in the field.

Mr. ASHMORE. Do these social workers and probation officers make repeated calls at certain stated times? Do they come in unexpectedly and unknown as to when they will appear so the addict will not be in a certain condition when they get there?

Dr. BRILL. Well, a certain number of unexpected visits can be made. Of course, visiting a person at his home one has to make an appointment or he may not be there. The only source of information then is from the neighbors or from the family which makes it difficult.

Mr. ASHMORE. Are workers available at any and all times to the patients?

Dr. BRILL. Yes; there are workers available at all times to the patients either by telephone or actually at the clinic.

Mr. ASHMORE. What is your idea about these people after they are released from the institution, going back to their old environments? Should they be permitted to do that or would it not be much better to provide a place for them away from their old friends and environment and the old atmosphere they were living in when they became addicted?

Dr. BRILL. There has been a great deal of controversy about this. Some people have felt that if the addict can be taken into another environment he then will break the associations and remain clean. The desires of the individual are pretty important. Unless one is willing to set up what amounts to further detention facilities the man will go to where his friends and associates are, his relatives, and this is an extremely difficult problem to solve.

Perhaps some of the experimental installations that are now being worked with, for example, in New York, may offer a solution, a halfway house where these people are gathered together and go out to work and receive a certain amount of supervision and support.

It may be that some type of intermediate facility of the type you have in mind can be developed.

Again we are awaiting some figures and facts as to how to do it, how much it costs, and what the results are.

Mr. HUTCHINSON. While I recognize there might be a constitutional question involved in the question I will pose to you, the thought occurs to me that perhaps as part of the voluntary curative program which the accused criminal agrees to undertake in lieu of being prosecuted for a crime that such an agreement might also include an agreement on his part that for a rather long period of time thereafter he

would not go back to certain communities, and so on, to make his home. In other words, as a matter of his own agreement he could be kept away from that environment.

Do you think that would work, or do you suppose the likelihood is that he would go back, anyway?

Dr. BRILL. I think one would want to examine the individual case. A homeless man who gathers with a group of other people in an unsavory neighborhood might very well be asked to take this as a condition, but a man who happens to be poor and who would be returning to live with his family, with a father and a mother, or with a brother or a sister, he might feel happier and more comfortable to go back with people he knew.

I have seen the other tried. They are like fish out of water. They are too far away from anything that they recognize as homelike. This creates another type of tension and another type of problem and frequently in the long run leads to relapse simply because he cannot stand it.

Mr. HUTCHINSON. Granted that each case is different, perhaps the law might authorize the judge to agree to let him take this civil commitment process, to have that power to require him to stay away in an appropriate case.

Dr. BRILL. I think he might very well in a specific case where the indications are clear cut. Perhaps this might be included; yes.

Mr. ASHMORE. Doctor, you are familiar with this law in New York State. We have a similar statute and statutes in California, although they vary in several aspects.

Dr. BRILL. Yes.

Mr. ASHMORE. Have you made a study of the California law, a comparison of it with the New York law, so you can give us your ideas with respect to which of the two is best? Is there anything you care to tell us?

Dr. BRILL. Of course, I am an interested witness here representing New York rather than California. I will see the advantages of the New York situation, of course.

The two laws in some ways are quite different. Our cases are grouped into a half dozen special units installed in State hospitals and under the care of specially trained psychiatrists.

The California law depends essentially on a large facility at Corona where the people are under a slightly different kind of supervision.

I visited it. I was very much impressed by their program. They carry out a type of group therapy under specially trained individuals who are not physicians but they are well trained in group therapy.

Both the New York system and the California system are relatively new. They date back to 1960. Actually the full-scale implementation in both States followed considerably afterward.

The type of case may not be exactly the same. I don't know how comparable the two groups are actually, but the most important thing is that neither New York nor California in my opinion is ready for a final evaluation of results, and, I think, perhaps it might be wiser to wait to see what the outcome will be after a sufficient length of time has gone by and a sufficient time is allowed for scientific control studies.

Mr. MCCLORY. I have a question along the same line. Other wit-

nesses who have appeared before this committee and have responded to similar questions as to their valuation of the New York system have indicated that the sole drawback in the New York system was the lack of funds.

Would you comment on that? Is that your view as well?

Dr. BRILL. Well, the budget has been very markedly increased during this last year. I think what we need is time to develop a more adequate technique for handling these cases and an opportunity to benefit by our own experience and the experience of others.

No; I would not say that money is the only problem by any means. The problem itself is a very difficult one. Anybody who has treated these cases knows that this is a difficult situation, and it will take patience on the part of everyone. If we are impatient we might find ourselves disrupting programs. I doubt whether we can hurry them beyond a certain point.

Mr. HUTCHINSON. If I may follow right along that line, Mr. Chairman.

Doctor, in view of your statement just made, are you of the opinion that a Federal aid program would be beneficial in the State of New York?

Let me develop that. I believe you said that you needed time and wanted to get some experience. You wanted to work out this program.

Is it not likely that with Federal aid you also have Federal control, interference, or at least the Federal Government will be involving itself into your program in a persuasive manner?

Dr. BRILL. I wouldn't foresee a conflict with the Surgeon General on our program.

Mr. HUTCHINSON. You say you would or would not?

Dr. BRILL. I would not. After all, we are guided by certain generally accepted professional principles, and if they are good they are acceptable everywhere and if they are not I think they are open to professional discussion.

I didn't mean to say that money would not be useful because money would very definitely be useful.

One of the most important limitations at the present time is that of trained personnel. As we work with this problem we are overcoming it. People have been exposed to the work and it all helps. I think with Federal aid our scope would be considerably enlarged.

Mr. GRIDER. Dr. Brill, I would like to ask you some broader questions about this problem. In your testimony you say that the problem in England has begun to explode and they are now getting street users.

After so many years of keeping the problem under control and it is suddenly getting out of control in England, to what do you attribute that?

Dr. BRILL. The history of drug abuse is very interesting. There are times when it spreads in an epidemic-like fashion.

After World War II in Japan, for example, there are now thought to have been several million amphetamine users. Japan thought that that country was relatively immune to heroin. Even though they were close to the continent of Asia they had virtually no known users.

In about 1950 they became aware of the fact for the first time in their history that heroin was infiltrating their borders. When I was there last November with a group they were worried about perhaps 30,000, 40,000, 50,000 heroin addicts in the country.

This developed very rapidly within a space of a few years, so that to answer your question directly—for reasons that are not completely understood, especially after a war or under conditions of social stress, but sometimes without it, addiction habits will spread like wildfire, and the most inflammable elements in the population are those who are under some sort of economic stress, and the younger groups. It spreads among young people. When it does it is very rapid.

Perhaps there is an analogy to the way other fads may spread among young people. However, there is no question but that it can happen and grow very rapidly if there is a supply of the drug, and the Japanese, of course, had the supply available from the mainland.

Mr. GRIDER. In those areas where the disease is an epidemic and the drug readily available, does it go in cycles, does the patient go up and down, or do we know?

Dr. BRILL. My experience is that it goes through cycles but I have no real good information on the subject.

There is good information that the type of drug changes from time to time. For example, in China opium was eaten until about 1700 when they developed the smoke-it habit. It was discovered then that opium is quite acceptable as a smoking substance.

They changed to smoking opium, and then in the last 50 years in the Far East the trend has been away from the crude opium and toward the hard, white substances, heroin and morphine, so that the type of drug changes.

As to the other question I cannot answer it, whether total use changes from time to time.

Mr. GRIDER. If the disease goes unchecked and the supply remains unlimited are there any cases of actually destroying a nation or a community with the great majority of the population getting the hook?

Dr. BRILL. A great majority of the population becomes involved. China, of course, usually is quoted as a horrible example of what happens when opium use goes unchecked. This was in the 1800's.

There is less attention paid to the very unhappy results of unchecked use of hashish, which is another form of marihuana, in the Middle East and Far West, especially in Persia.

Mr. GRIDER. What is the curve of addiction doing in this country right now?

Dr. BRILL. Our best information is that addiction in this country has slowly diminished for several years. Actually what happened, the total story, is that there was a heavy incidence of addiction up until about 1920. Then it gradually decreased so that before World War II addiction appeared to be on the wane.

During the war it dropped to a really low level.

After World War II there was an increase, and then in the 1950's there was a rather sharp increase, in the early 1950's, and now we are going back down again. However, we never reached the 1920 level and the best information I know is that it is declining, but slowly, at the present time. I speak of heroin.

Mr. MCCLORY. The question I had was this: You were talking about areas where this problem is concentrated and groups with which it is most prevalent.

I was just in the State of New York, where the problem is primarily

in the city of New York, and primarily among the Negro and Puerto Rican communities. Is that correct?

Dr. BRILL. That is correct. There was a parallelism. The Korean groups were very heavily involved in Japan, a minority group. However, this is not universally the case. The British did not find that their minority groups were involved. These were native British.

Mr. MCCLORY. We had a doctor who testified before us yesterday, who was very sharp in his criticism of the use of methadone as a means of curing an addict. I notice that you have referred favorably to this method of treatment.

I would like to have your opinion as to the efficacy of methadone as a method of handling the addict.

Dr. BRILL. I did not mean to take a favorable position. This was a broadminded, or openminded position, perhaps. At least that was my intention.

Methadone is not intended as a cure of addiction. Methadone is the substitution of a less vicious addiction for a more vicious addiction, and the hope that lies behind it is that by satisfying the craving with methadone one may forestall the use of heroin which is even more destructive.

The scientific question is how many people, if any, can be given methadone, and while being satisfied with methadone can live a reasonably satisfactory and constructive existence.

I personally feel, and I think most people in the field feel, that this is by no means a method for extensive use, but there is a scientific question which is unanswered—whether a small group of people can be carried on this sort of a regime in a constructive way. This is under trial at the present time.

The controversy, the field of scientific controversy, is a very narrow one, whether it is 1, 2, 3 percent, and so on, but as a solution across the board in New York I would say this is out of the question.

Mr. MCCLORY. There is a scientific controversy, there is a pilot operation in operation, and the scientific controversy undoubtedly will be resolved as a result of this pilot program?

Dr. BRILL. It is to be hoped we will have some definite information. There already is some information as to the limitations, and so on, but it is too early to say.

If I may say one more word. The people who are most interested in this methadone idea hope that by giving enough methadone the patient will be so insensitive to a small additional amount of heroin that it would not do him any good to buy the heroin, and in the New York area our experience within the last few years has been that patients are unable to buy large supplies of heroin and serious heavy addiction is the exception. They get a very small amount. They buy it but get very little for their money. The result is that physical addiction is relatively mild. This is a change and a very definite improvement in contrast to 10 or 15 years ago.

Mr. HUNGATE. Doctor, what is your view of the mandatory minimum sentence for offenses of narcotic addicts?

Dr. BRILL. I think I should say I am not qualified to give you an informed answer. I have not had experience with the correctional side of this work.

Mr. HUNGATE. Would that same answer apply to the question of denial of probation?

Dr. BRILL. I can see why one would want to have the privilege of probation to motivate a prisoner, just by analogy with our own work. Judging from our own work one would wish to have that right in treating an addict.

Mr. SHATTUCK. In the discussion of facilities and personnel, what is the bigger problem, Doctor? Is it personnel or facilities which is the real problem?

Dr. BRILL. We need to expand our facilities, but the problem is the training of personnel in this particular field, and this will take some time. I think it is being overcome.

Of course, there is a manpower shortage in all the technically trained professions and this is part of a general manpower shortage of doctors, nurses, social workers, psychologists, and so on.

However, within the framework of that shortage I think we can make progress.

Mr. SHATTUCK. Is it not contemplated that there will be a very small caseload for the worker in this field?

Dr. BRILL. Yes. The figure which is most frequently mentioned is the figure of 30 per social worker, 30 patients per social worker.

Mr. SHATTUCK. Would it be anticipated that this worker, be it a psychiatrist or a social worker, would be available to the given addict as an individual undergoing this program who would look to one person for his aid, consultation, and whatever it is that he needs, or would it be necessary for him to go elsewhere?

Dr. BRILL. His primary contact would be to go to one person. Of course, no one person is continuously on duty, and therefore the organization still must play a role. Then there are some special services, too. What the psychiatrist does is somewhat different from what the social worker does, but the bulk of the time which the patient would spend with the organization after he leaves would be with the social worker, and this probably would be his primary contact.

Mr. SHATTUCK. Would it be contemplated that this clinic or center would be available on a 24-hour-a-day basis or would it be required that the individual make appointments, come in at a specified time?

Dr. BRILL. Up to the present time the organization and clinic requires appointments. However, the hospital operates continuously and an addict who needs to contact the hospital outside of hours can do so and can get help whenever he wants to.

Mr. SHATTUCK. The question of environment is next. Wouldn't it be an unusual case for the individual who had ties to his environment, you mentioned the homeless individual, but the person in a family situation or who works and has gone to school in a given area, eventually he will have to return to that area most likely. Would it help to try to remove him from that environment other than for the initial stages of the treatment?

Dr. BRILL. This is an unresolved question.

Mr. SHATTUCK. You see what I mean? Eventually he will have to go back there, anyway.

Dr. BRILL. Yes. This is a very involved and difficult question which has emotional aspects.

Some men can conceivably break their ties and go elsewhere and pick up new associations. Many, many will wish to return. As you point out eventually they will return to their own neighborhoods.

Modern society has a good deal of mobility and people do move around, so I do not think that there is a real across-the-board answer. It will depend on how many cases will wish to resettle and will be able to resettle and the number of cases which will not wish to resettle but wish to return to their own neighborhoods. This remains to be worked out.

Mr. SHATTUCK. This type of person may not be a very adaptable person at all, or he might not have been in this situation to start with.

Dr. BRILL. The addict as a class, and here you can generalize somewhat, cannot stand frustration. He cannot stand delay in satisfying his demands. He must have what he wants right now. This is a fundamental problem.

Nevertheless, as you know, the Synanon group has gathered a small number which have been willing to move a good distance away from their homes. This is a select number out of a large population.

Mr. SHATTUCK. They have a certain motivation or they would not have joined together in this kind of operation.

Dr. BRILL. Exactly. You can find out of large populations an example of almost any type of procedure which you like, but when you ask a question which involves 30,000 people in New York, for example, then in general I think you get a different kind of an answer.

How many of our people would be willing to resettle is a serious question.

Mr. SHATTUCK. One comment I would make, Doctor, and that is in connection with the bills pending before this committee. The primary trust is the treatment of an addict. In order to comply completely with this program it seems somehow difficult how methadone, an addicting drug, could fit into this picture except perhaps on a very temporary basis.

Dr. BRILL. I would agree with you. In all fairness, however, I state the opposite point of view in order to give you an answer. The opposite point of view is that here is a man who wants nothing more than the satisfaction of a certain chemical craving, and if you meet his demands then he can go on and be a productive, useful, and happy member of society.

My own experience is that this is not so, that he takes what he can get, that he may sell this at one time, and another time he may buy additional supplies. As a matter of fact, one of the serious problems they have in Britain at the present moment is that these people come in, get a rather good supply from the physician, even though it is very much frowned upon, and they go out and sell it, so the unreliability of the average addict absolutely contradicts the use of this technique for such cases.

As to the exception—perhaps they are exceptions but they only prove the rule.

To return again to what you have to say, I certainly would agree that to my mind this is not a cure, nor does it approach a cure.

Mr. SHATTUCK. My point in raising it was this: Except as an indication of a certain line of research it is not relevant to this bill because the bill provides that the man shall be cured of his addiction and take his place in society. If he does not do that he has to stand trial for the criminal offense.

Dr. BRILL. I think I would agree with that.

Mr. SHATTUCK. Thank you, Doctor.

Mr. ASHMORE. Mr. Hoffmann?

Mr. HOFFMANN. I have one or two brief questions. Can you give us any figures from your own experience on the incidence of criminal behavior prior to addiction? This is in the context of the bill talking about treatment, not just the treatment of addicts in drugs but a very specific class of addicts, those charged with crime. That is what we are talking about here.

The first question are statistics.

Dr. BRILL. A very large portion of addicts have been criminals before, they have been arrested before, they were known to be addicted. However, if you ask for my own personal experience I find it extremely difficult to be sure because addiction may exist without being known, and unless one has objective criteria he has to depend on the history given by the addict himself. This is uncertain.

Mr. HOFFMANN. You would concur that generally there is a pattern of antisocial behavior?

Dr. BRILL. There is generally a pattern of antisocial behavior which accompanies it. My own opinion is that it frequently precedes it, that it springs from an environment where there is a great deal of antisocial behavior and in a not inconsiderable number of cases antisocial behavior may continue when the addiction has ceased.

Mr. ASHMORE. Is it not true that practically all of them are innately weak people, anyway, weak mentally, psychologically, or in that sense?

Dr. BRILL. I understand your point. It is certainly true that there is a psychiatric weakness but it is also true that a very large proportion of the population will have a psychiatric weakness, and why in this group the psychiatric weakness expresses itself as addiction is an unsolved problem.

One can show psychiatric weakness in 25 percent of an average population, and this is a conservative figure, so that with psychiatric weakness being so widespread it is something to consider when one says "Well, these people are psychiatrically weak and therefore nothing can be done for them and therefore they will be victims of addiction."

There are many, many people with psychiatric weakness who are not addicted and lead a normally satisfactory life.

Mr. HOFFMANN. As a doctor contemplating an addict charged with a crime, what do you think the positive advantages from the point of view of treating this man are in a law which allows him to be civilly committed before he is held to account for that crime as opposed to being treated in the course of confinement which results from a conviction?

Do I make myself clear?

Dr. BRILL. Yes. I think I understand you to ask what is the advantage of hospital treatment over rehabilitation and correctional facilities.

Mr. HOFFMANN. What is the advantage to you as a psychiatrist in treating this patient in setting aside the question of his criminal responsibility and curing him first? In other words, simply, do you advocate trading a crime for a cure?

Let me give you a concrete example. A man is caught shoplifting in Washington at the Hecht Co. He is taken to headquarters. They find one or two capsules of heroin. They check his arm and they say he has had it.

Under different laws he should be cured of his addiction because probably there is a causal relationship between the criminal act and the addiction.

Is there advantage to you when you are treating the addiction in having him with the case hanging over his head as opposed to having him convicted and having him held to account for society's sin and then providing a cure, which would be the same cure. He can be put in the hospital just as easily afterward.

Dr. BRILL. There is a great advantage to having this hanging over his head. Such a patient, who has an outside influence to strengthen him against himself, this strengthens a man's resolve. Such a man is easier to treat than one who does not have any outside reinforcement of his better nature.

Whether it is better to treat him while this thing is pending so that he knows that he will be able to leave after he is better or whether it is preferable to have him convicted and then sent to a correctional facility—is that the question?

Mr. HOFFMANN. Yes.

Dr. BRILL. And then treated after he leaves the correctional facility?

Mr. HOFFMANN. Give the same treatment as you give him under civil commitment only before that you have convicted him of a crime.

Dr. BRILL. And he is then convicted and his sentence runs while he is under treatment?

Mr. HOFFMANN. Yes, sir.

Dr. BRILL. Can he be released by the physician when the physician feels that his condition warrants?

Mr. HOFFMANN. No. This is hypothetical but suppose you have the basic treatment period you have under several of these proposed bills.

Dr. BRILL. And he has to stay in the institution for 2 years?

Mr. HOFFMANN. Stay in the institution for a few years and released thereafter for another year, dependent upon his good behavior.

Dr. BRILL. I would very much prefer having the authority to release him when his condition medically warrants it.

Mr. HOFFMANN. For the context of his having committed a crime under these bills you would not have that option, you see. He is either civilly committed for 3 years or he gets an enlightened treatment as he would get in Kentucky under the present law.

There are various alternatives. One of them is to hang this crime, suspend it, and civilly commit him.

In the administration of the criminal laws there are severe drawbacks to doing this. There are other options which are open to lawyers and there is a procedural disadvantage to watering down certain standards.

One of these judgments will have to be made, and that is whether this preconviction treatment is really worth the cost it will be to the system, not cost in terms of dollars but sacrifice in terms of efficiency.

I am trying to get your views on this just from the point of view of the doctor.

Is this helpful, and if it is helpful is it helpful enough?

Dr. BRILL. I now speak from experience because the Metcalf-Volker law does exactly what you say.

A man is not convicted. The case goes into abeyance. If he co-

operates he is put on convalescent care, discharged, and does not go back to court any more. The charges are dropped.

I think that with the types of cases we have chosen there has not been an undue motivation of the criminal to take this as the easy way out. I don't believe this has been a problem at all simply because the offenses have not been that serious that this is an easy way out.

He puts himself under several years of supervision and many of these people will feel that he might possibly get a light sentence or get off altogether if he goes up to face the charges.

I think if we are speaking about a trade of a crime for treatment the trade has not been that disproportionate in our experience.

Mr. HOFFMAN. Under the laws of New York, if he elects to go to trial there is a problem there of crowded dockets. He may be able to get his lawyer to talk the thing down into a misdemeanor rather than a felony. There is a safety valve.

Under this bill he would not have that. There is a 5-year minimum in many situations. The question then arises—is it better to have over him the possibility of conviction, or have him toe the line and recognize he was wrong and start from there?

Dr. BRILL. I am perhaps not in a position to comment on the second part of your question partly because I am not sure under what condition the treatment will be carried out.

If a man could be treated after conviction with the same degree of flexibility as he is treated in New York now before his conviction, I would see no problem. However, if the conviction were really to turn his treatment into a period of incarceration in the hospital with no flexibility, I would see serious drawbacks to medical procedure.

I hope I have answered the question.

Mr. ASHMORE. Mr. Hoffman, perhaps this might get at what you have in mind a little more directly, and perhaps the doctor can comment on it more in detail from a different angle.

The State of New York, in order for the defendant to get treatment and be civilly committed, does not require that he be tried or plead guilty to whatever offense he has committed, if I understand correctly.

Dr. BRILL. That is right.

Mr. ASHMORE. If he decides to select civil commitment the crime is laid aside and held in abeyance, and if he completes his treatment and rehabilitation under the civil commitment program the crime is forgotten and marked off and he does not have to face it at a future date.

Dr. BRILL. That is right.

Mr. ASHMORE. In the State of California under their law he comes up charged with the same offense that he might have been charged with in New York, but there the circumstances vary in this regard—he is first required to plead guilty to the offense or he is actually tried and convicted of the offense, but everything is held in abeyance insofar as punishment for the offense is concerned if he selects the civil commitment program.

Dr. BRILL. Then.

Mr. ASHMORE. Then he goes on and completes his treatment and rehabilitation.

Then the crime to which he had pled guilty, and for which he was convicted, is removed from the record, expunged from the record

entirely, and he is not held as having been guilty of that crime at all.

Which of the two do you think is better, Doctor?

One, he goes in under conviction, knowing it can be removed from the record and he will not be held responsible for it, not even tried for it?

Dr. BRILL. I think it is technically easier for him to have pleaded guilty rather than to try to bring the case to trial after the whole thing has become old and the witnesses have disappeared and the defenses may be difficult, and so on. This I understand quite well.

I think unless it is a serious offense it would not make a great deal of difference because if he knows he has to face the charges this is still enough of a deterrent to him so that he will cooperate.

Mr. ASHMORE. From the medical treatment standpoint you don't think it will make much difference?

Dr. BRILL. That is right. From the legal standpoint I can see it would be important, just so long as the physician has the flexibility to let him go out when he feels that the patient's condition warrants it.

I don't see that that would make any difference at all.

Mr. SHATTUCK. The bill, H.R. 9167, which is recommended by the administration, the Justice Department, and the Treasury Department, provides certain alternatives on this basis. It provides for a civil commitment prior to conviction and then after conviction it provides a similar program, perhaps with one reservation, the sentence and the conviction still standing.

Therefore, this bill provides the court with a certain choice, but I think there may be some relevancy here in the fact that the bill seems to infer there is an advantage to not proceeding to a conviction, that this will help in the rehabilitation and treatment process.

Do you have any comments to indicate that perhaps it is a distinction without a difference? I don't want to be unfair in questioning you but we have a problem in the bill and any comment you might have will be helpful. I am sure.

Dr. BRILL. I was involved in the drawing of the Metcalf-Volker bill. We went through this question and discussed it back and forth a number of different ways. It was finally decided to suspend the proceedings and not to go on with the conviction in order to have the individual—well, we hoped more people would choose the hospital way out without going on to a conviction.

Mr. ASHMORE. Induced to take the treatment?

Dr. BRILL. And be induced to take the treatment. This was the motive behind it.

Once there has been a conviction you might lose many cases. This was the logic behind it, at least part of the logic.

Mr. HOFFMANN. What is the method under New York law? There is some connection between the crime and the addiction, or is this required?

Dr. BRILL. Yes. When the case is examined the facts are reviewed by the court and the facts also are reviewed independently by the department of mental hygiene.

If the court, or if the psychiatrist reviewing the case, feels this is not a treatable condition, a treatable condition of narcotic addiction, the case is not accepted.

Mr. HOFFMANN. By what procedure—this may get out of your expertise—but by what procedure is this done? Is it a hearing? Does he have a right to demand why he is not allowed to go under civil procedure?

How does this work in New York?

Dr. BRILL. He is not allowed to question. There is no question about it. If he is accepted he is accepted and if he is not accepted he has no further appeal. If he is not accepted for hospital treatment he has no further appeal.

Mr. HOFFMANN. Has this been tested in the courts; do you know?

Dr. BRILL. No; it has not, but the law is carefully drawn to allow us to refuse cases which do not seem to be suitable.

Mr. HOFFMANN. In the Federal jurisdiction under the Bill of Rights of the Constitution you have problems of this kind where although the law is drawn very clearly, it is discretionary with the judge and there is no need to put out findings again and again and again.

If you provide prior to conviction an alternate path down which by judicial action a man will be sent, he has the right at that point to a full hearing and a right to know why he is getting one rather than the other. This is not so in New York?

Dr. BRILL. Not to my knowledge.

Mr. ASHMORE. Doctor, thank you very much for your fine statement. It has been very helpful.

At this point we shall insert the statement of our distinguished colleague from New York, Mr. Lindsay. He was unable to attend because of another important commitment.

(Congressman Lindsay's statement follows:)

TESTIMONY BY REPRESENTATIVE JOHN V. LINDSAY

Mr. Chairman and members of the subcommittee, I welcome the opportunity to testify today on bills I and other Members have introduced to achieve what I believe to be a more enlightened and humane policy toward the national problem of drug addiction.

The misuse of narcotics has been an immediate and compelling interest of mine throughout my tenure in Congress. It is a destructive influence in the congressional district I represent and elsewhere in New York City, where almost half of all the known narcotics addicts in the United States reside.

For example, the first murder committed in New York City in 1965—possibly the first in the Nation this year—took place just off Times Square early New Year's Day. Not surprisingly, the victim was a known user of narcotics.

Homicide is the most spectacular symptom of the malignant drug traffic infecting our society. Not so well publicized are the thousands of robberies, burglaries, and assaults perpetrated as a direct result of the pernicious misuse of narcotics. Little attention has been paid, moreover, to the subtle manifestations of the disintegration of self through drugs—the addicted father, the addicted daughter, the addicted wife.

The tragedy of the addiction is that the disease for the most part affects the young—50 percent of the Nation's addicts are under the age of 30; 90 percent are under 40.

These unfortunate individuals steal an estimated one-half billion dollars yearly; in New York City they commit 50 percent of the serious misdemeanors and about 20 percent of all the felonies against property.

The overwhelming majority of narcotic addicts are not regularly employed. Many exist by stealing, prostitution, or dope "pushing."

Thus, addiction is both a debasement of the individual and a detriment to society. Its effects are manifest; the cure is not.

According to the Federal Bureau of Narcotics, almost 50,000 narcotic addicts live in the United States. This figure may be much too low; it has been estimated that 50,000 addicts are residents of New York City alone.

For too long, addicts have been dealt with almost exclusively by the police, the courts, and the prisons. Existing Federal law provides severe penalties for narcotics "pushers," those depraved purveyors of moral subversion. This is as it should be. But the law subjects addicts to prison terms almost equally severe.

To my mind, this procedure has proven its inefficacy. The solution to drug addiction—as opposed to the exploitation of addicts—will not be found in the prisons. It will be found in the clinics and hospitals.

For although the drug user may become a criminal because of his addiction, he fundamentally is a sick person and should be treated as such. What should concern us most is not punishment, but the far more difficult process of ending the user's compulsion toward drugs and his dependence upon them.

This concept—that those who misuse drugs should be viewed as the sick in need of the physician rather than criminals in need of judgment—forms the basis for the four bills I have before this committee. They are numbered H.R. 8888 through H.R. 8891.

The first of these bills provides for the civil commitment of persons charged with violating Federal narcotics law. Those who sell drugs for resale would be exempted. The bill follows the lines of legislation adopted by New York and California.

At present, narcotics addicts often elect to plead guilty to a charge and serve a prison sentence rather than be treated in a hospital such as the one operated by the U.S. Public Health Service at Lexington, Ky. The reason is that the time spent away from drugs is likely to be shorter.

My bill provides that when a person charged with the criminal misuse of narcotics is brought before a judge, he be given 10 days in which to decide whether to face prosecution or submit to an examination, to determine if he is a narcotics addict. If the accused submits to an examination, and the finding is positive, the court is empowered to assign the defendant to the care of the U.S. Surgeon General for up to 36 months for treatment and rehabilitation. If the finding is negative the accused would stand trial.

The bill also provides for a 2-year period of probationary aftercare upon the addict's release from a hospital.

If the addict was rehabilitated during this period, the original criminal charge would be dropped. If the addict returned to drugs, however, he would face prosecution. Any time spent in the hospital would be credited against what prison sentence might be imposed.

Addicts would not be eligible for civil commitment if they were charged with, or had been convicted of a crime and had not served their sentence; if they had been convicted of more than one felony; or if they had been civilly committed twice previously.

I believe the civil commitment process introduces a new element of discretion and flexibility to the harsh rigidity of our present attitudes toward narcotics addiction. As early as 1961, I introduced a bill in the House providing for this method of disposition. It does not coddle drug abusers. It does, however, recognize that the answer to addiction is to be found more in psychology than in penology.

It should be pointed out, parenthetically, that almost 5,000 narcotics addicts presently are in Federal prisons and it costs the United States about $10 million a year to keep them there. Yet most return to drugs upon release. It will be far less expensive and much more humane, in my judgment, to adopt a program designed to deter addicts from imprisonment by restoring them to useful lives.

The second measure follows the outline of a bill I introduced 4 years ago. It authorizes the appropriation of $15 million in each of the next 3 fiscal years for grants to the States to construct treatment and rehabilitation facilities for drug users. The Federal Government would pay up to two-thirds of the cost of these facilities.

The third bill establishes a $7.5 million per year program to help States provide job training, family counseling, psychiatric care, and a wide range of services to enable addicts who have "kicked" their habit to return to society. The program also has a two-thirds matching provision.

The fourth bill would modify the now mandatory prison sentences imposed on addicts to allow Federal courts more latitude in the use of parole, probation, and sentence suspension. The salient provision would end the existing 5-year minimum sentence imposed on users. The mandatory sentences for narcotics sellers, however, would not be changed. The revision should prove of particular benefit in rehabilitating young, first-time offenders.

I believe this legislation represents a progressive and worthwhile modernization of our philosophy toward drug addiction. It recognizes that to wipe out the despicable narcotics traffic we must eliminate the need. It will not be an easy course, but it is one we must follow. It is conscientious, it is sound, and it will get results. Certainly our current system does not.

The bills I introduce are vitally important to New York City and to the Nation. I join with other sponsors of this legislation in calling for committee approval and swift enactment.

Mr. ASHMORE. We shall adjourn subject to call of the Chair.

(Adjourned at 12 noon.)

BILLS PROVIDING FOR CIVIL COMMITMENT AND TREATMENT OF NARCOTIC ADDICTS

THURSDAY, AUGUST 12, 1965

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE NO. 2 OF THE
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 o'clock in room 2141, Rayburn House Office Building, Hon. Robert T. Ashmore (chairman of the subcommittee) presiding.

Mr. ASHMORE. We will resume our hearings on the narcotic bills.

We have been placing particular emphasis on the commitment and treatment phases of these bills. This morning we have an expert with us whom we are delighted to have to come and bring us the benefit of his knowledge and experience. I believe much of his experience has grown out of research. Mr. Richard H. Kuh, of New York City.

Mr. Kuh, you may read your statement in full, you may summarize it, or follow whatever procedure you desire.

STATEMENT OF RICHARD H. KUH, NEW YORK, N.Y.

Mr. KUH. Thank you, Mr. Chairman. I am most appreciative of being asked down here.

What I would like to do is read the statement, but I hope that all of you gentlemen will feel free to interrupt as I go along with any questions which may occur to you. Certainly I will be pleased to handle questions just as you may choose.

I was requested to appear here today, according to my own understanding at least, in order to give you some picture of what we in New York State expected from our 1962 Arrested Narcotic Addict Commitment Act and what, in fact, we have gotten. There is some difference between the two. By discussing the strengths and defects of both the New York act and of its execution, and comparing the act with the two bills before your committee, hopefully I may be able to assist you in judging these proposals.

The New York act is the prototype upon which both the administration's bill, H.R. 9167, and your committee chairman's bill, New York Congressman Emnauel Celler's bill, H.R. 9051, were in large part based.

I have brought with me copies of the New York act, and I will hand them up. I assume you have some in your files. These are further copies.

Like our New York statute, the bills which you have before you provide that the arrested drug addict may under some circumstances

elect to be committed to the care and custody of medical personnel, in lieu of having the charges against him processed in the criminal courts. The charges then are to be dropped, once the medical authorities certify that the former addict has successfully completed his treatment program.

I am pleased and honored to have been asked to appear before you, and I hope I may be excused for a little bit of vanity. In the fall of 1960, as the then administrative assistant to the district attorney of New York County and the then secretary of the State District Attorneys' Association in New York, I first devised and suggested this civil commitment program in lieu of criminal processing for the arrested addict. Others previously had urged that at the time of sentencing, hospital beds be substituted for prisons. The idea of removing the addict from the courts and from our entire penal-correctional framework promptly after his arrest was a completely novel one. This, as you gentlemen know, is the basic difference between the New York program and the California program.

The proposal that I prepared died during the 1961 legislative session, but then in 1962 it was embodied in the broad attack on addiction in New York known as the Metcalf-Volker bill. That bill passed both houses of the State legislature unanimously, I am pleased to say, in 1962. On March 21 of this year, Gov. Nelson A. Rockefeller signed it into law. The bill was signed into law and was effective March 21, 1962, although the particular portion dealing with the arrested addict was, by the bill's provision, not to become effective until the following January 1 to give everybody time to tool up for it.

Upon signing the bill, the Governor hailed particularly the treatment the bill provided for the arrested addict, saying:

> Many narcotics addicts under arrest whose most serious failing is their own tragic addiction will be given an opportunity under the provisions of this measure to become self-respecting and self-reliant members of society through State hospital treatment and rehabilitation.

The hopes of all of us, from social workers through police and prosecutors, who had been dealing professionally with drug abuse in New York, where unhappily the plague of addiction has been our Nation's blackest, were very high. I am sorry to say that those hopes have in large part been continually frustrated since the time of our Governor's optimistic words of almost 3½ years ago.

I understand from your counsel, Mr. Shattuck, that some have urged upon you and that many of you have questioned in your own mind whether the New York approach or the California approach is preferable. The New York approach is the approach that basically is adopted in Congressman Celler's bill and the administration bill. It is the approach that substitutes postarrest election of hospitalization and aftercare for criminal processing, and the California approach is one of mandatory postconviction hospitalization and aftercare. I urge against the California approach, and I urge in favor of the approach in the two bills before you.

Although, sadly, the New York law has not to date had broad impact, and although I am informed that that of California has shown very good results, I strongly believe that New York's failures have been attributable to our act's routinely dull and small-scale administration, and not attributable to any defects inherent in the act itself.

I believe our own New York abysmal administrative failures may light the way to Federal legislation and possibly to amendments to our own State legislation that will prevent or cure such weaknesses in the future.

My discussions with you I should like to break down in this fashion. First, I should like to review with you the theory behind the New York type of prompt, postarrest commitment. Second, I would like to sketch for you some of the defects in practice in New York's program. I shall then suggest ways legislatively of anticipating and coping with these defects. Lastly, I shall make some specific observations concerning both the Celler and the administration proposals.

Basically, the New York program is premised on the idea that the addict is not simply a criminal nor simply an ill person. It is an oversimplification to make that dichotomy of one or the other. Rather, he is a public health problem. He is a person both infected by and carrying a highly contagious disease—contagious in the sense that addicts use drugs socially, bringing their "infection" to others in their communities who are prone to addiction. As one who is infected, the addict should be treated medically, humanely, in an effort to cure him. As a disease carrier, however, he must be quarantined in order to protect others. And as one who is both diseased and communicating infection to others, he must be treated promptly. This I underscore as one of the differences between our law and that of California. His treatment should not be delayed until a variety of pretrial motions have been processed and other adjournments and delays have been tolerated, but should start as soon as is feasible after his arrest.

I should like here to interject that our experience in New York, of course, is that most addicts, probably just to pull a figure out of thin air which may not be accurate, 70 percent, are impoverished, not good bail risks, and do not make bail, but there is always a portion of the addicts, probably 30 percent or maybe more, who do make bail. I have seen delays of more than a year in getting those cases to trial. So you have a situation where the person has been arrested in possession of drugs or arrested for another crime but is addicted, and is released on bail and the case drags on while he continues to nurture his addiction on the outside before you have done anything with him. This is if you cannot do anything with him until after he is convicted.

I think this is foolish. I think it shows that the law is not acting effectively with the addict since it releases him promptly when he renews his habit.

Mr. ASHMORE. They are released on bail and have to await trial for quite a while.

Mr. KUH. Under our present law, if the addict makes the election of hospital commitment in lieu of criminal processing, he cannot be released on bail. Upon making that election he goes promptly to the hospital. That is one of the reasons for our adopting this law. It avoided the travesty of the person's not only being out and continuing to take drugs while the criminal charges were pending, but not infrequently we have persons out rearrested and rearrested a third time while the first case still had not been disposed of. If you are going to treat the addict as a public health problem of some kind, it makes no sense in effect to pat him nicely on the shoulders and say, "Continue your habit for 6 months or 8 months or a year until after we finally have convicted you and are able to do something about it."

At any rate, it was obvious to us in New York that the criminal courses I have just indicated were not well suited to the addict treatment.

Mr. ASHMORE. You have mentioned that the addict should be treated promptly and the California law does not provide that prompt treatment. What is the difference between the California and the New York laws?

Mr. KUH. My understanding is that the California law has various commitment proceedings, but the key one and the one that we are concerned with in the Celler bill and the administration bill, I think, is what is done with the arrested addict. Under the California law, as I understand it, nothing is done with the arrested addict at that point; but after he is convicted, instead of the court's sentencing him to an institution, I am not sure of the names of the California courts but I think it is their supreme court that then will commit him to the California correctional authority for treatment of his addiction. But if the addict has been out on bail in the meantime, this may be not only weeks but months after his arrest.

In New York the addict, if he wants to be treated as a sick person, must promptly make his election. If he promptly makes his election, then he is sent right to the hospital and never is back on the street from the moment of his arrest until the docors decide he is a safe bet back on the street.

That is the main difference. In other words, do we take the sick man, the public health menace, and transfer him from police custody, in effect very brief detention facility custody, right to a hospital, right into the hands of the doctors, or do we have a period which may be weeks or months or even more than a year's delay in the interim? California has the delay. New York does not if the addict is to be treated as a public health problem. Under the New York law the addict can reject the election. He can say, as I discuss further in my formal statement, "I don't want to elect to be treated as a sick person. I would just as soon be processed criminally." If he makes that election, then we have all the delays that California has which are inherent in our criminal processes.

Without the New York law and before 1962, it was our experience that even at the time that sentencing was finally reached, you had a conflict. The addict was likely to be some sort of football between some of our legislators, with all respect to legislators, who sought to blanket the courts with mandatory minimum sentences which compelled the courts to send the addict to jail for certain specified times. On the other hand, we had many judges who resented this and, I think at times misguidedly kind, sought to show understanding for the individual, frequently at considerable cost to the community, and would suspend sentences to so-called sick persons before them. Invariably these persons would be back again, rearrested in short order.

We had nothing and, I am sad to say, still have virtually a revolving door in New York because of the small impact of our statute. Very shortly I will discuss why our statute has not had the impact it might have had.

What we needed when we drafted the statute in 1960 and 1962 was a way of getting the addict into medical care promptly, keeping him hospitalized until it was safe to release him for an extended period

under close in-community supervision and, above all, we needed a method for motivating the addict to work with the doctors, to work with the medical personnel, to work with the aftercare personnel to achieve his own salvation from the course of his drug habit.

The postarrest election of medical supervision in lieu of criminal processing was designed to accomplish this. It got the addict into a medical program promptly. As the Attorney General of the United States, the Honorable Nicholas Katzenbach, testifying before you gentlemen on July 14, said:

> The great advantage of pretrial civil commitment lies in its emphasis on swift medical and rehabilitative treatment. Addiction is spread by the addicts themselves. Keeping them off the street in itself represents an important obstacle to the further spread of addiction.

Motivation to cooperate with the doctors was provided in the New York statute in two different fashions. First, the addict was promised that he would be spared the onus of criminal conviction if he was cooperative. That, incidentally, is not, at this point at least, part of the California law. He is criminally convicted. It is my understanding if he successfully completes their commitment program, there is a way then of nunc pro tunc obliterating the conviction, but he is convicted.

We are getting into something different here, but this is addiction, and I am one who believes that fictions in the law that tell a person who has been in trouble with the law that he can truthfully answer the question, "I have never been convicted," when in fact he knows he has been convicted—I think this gets into another area, but I do not know that this breeds respect for the awesomeness and dignity of the law.

I think if you want to prevent a man from being convicted, you anticipate it and you prevent him from being convicted. To convict him and say, "If you are a good boy we will fix it up so if anybody ever asks you if you have ever been convicted you can say 'No,'" to my mind, at least, and in the minds of some other people, is not in the interest of really creating respect for the law.

Mr. ASHMORE. What has been your experience or the New York experience with reference to trying a case a couple of years after the thing happened? It may be that he elects to take the civil commitment and then he does not make good, so you have to try him. He should be tried. What about the witnesses and the evidence? What has been the result of that?

Mr. KUH. There are several answers to that, Mr. Chairman. One, for the most part the addict's failure to work effectively under the program is ordinarily clear to us within 4 or 5 months. The State mental hygiene department is administering our program. They have a period of about 90 days during which they hold the addict committed. This is not foolproof, but the overwhelming percentage of addicts who fail is likely to fizzle when first put on the aftercare program, when first let out and first back in the community and when all the temptations are before them.

So, in most cases the addict who will fail his mental hygiene program will probably fail within 6 months or so.

If we have gotten him into the program, as our law provides, immediately upon arrest, then he is available to have the case tried against

him within roughly—as I say, this is not foolproof—6 months or so, which is probably almost as good as our normal criminal timetable is today, anyway.

Second, most addict arrests, in fact, 95 percent, let us say, of those who are arrested for a narcotic crime, are arrested by personnel of our police narcotic bureau. They have notes. They do not disappear. They are available. These are cops. These are professionals. So, whether the case is tried a week after the arrest or 7 months after the arrest makes very little difference in those cases.

Third, as to those who are tried for nonnarcotic crimes, where they may be dependent on nonpolice witnesses, the district attorney under New York law, which is something that is not in either of the bills which are before you, has veto power. For instance, if you have the case, Mr. Chairman, of an addict who is arrested for assault and then he says, "I am addicted and please civilly commit me instead of trying me for assault," the district attorney has veto power. If the victim of the assault is a floater, someone who is unlikely to be available 4 or 6 or 8 months hence, the district attorney can legitimately consider that factor and say, "No; this man will have to be tried for assault."

This is not in my formal statement and I should at this point interject that New York's law does permit the court, on conviction, to send the addict to a mental hygiene hospital or facility. That is rarely used. If you had this case of the person charged with assault whom the district attorney denies the civil commitment program because the victim of the assault is a floater, that person could be promptly tried and convicted, assuming we could get him to trial promptly, and then could be sent to a mental hygiene facility.

Mr. ASHMORE. Does the district attorney alone have the authority, in his own discretion, to deny the defendant civil commitment, or must it be jointly approved by the district attorney and the judge?

Mr. KUH. No, Mr. Chairman; in dealing with the person charged with a narcotic crime, possession of drugs, possession of a hypodermic needle, the district attorney has no veto power, no say or discretion at all, and the judge must commit him or must submit him for mental hygiene's approval. The State hygiene department has an absolute veto, and they need not explain it. They can refuse to take anyone they wish. But the judge must submit him to mental hygiene if the defendant elects that commitment, unless he is within one of the stated statutory exceptions.

Mr. ASHMORE. It depends on what the medical experts determine.

Mr. KUH. To a large extent. One of the statutory exceptions is in the interest of justice. This is very broad language. I have attached to my formal statement a tabulation for the year 1963 which shows 1,093 persons applied for mental hygiene commitment, and only 11 were denied commitment by the court in the administration of justice. So, basically our judges have little discretion and, as I say, in the case of the narcotic crime, the district attorney has none. When you get to the nonnarcotic crime, the persons who are arrested for assault, unlawful entry, or burglary or whatever the crime is, certain of our nonnarcotic crimes are exempt if they carry a mandatory minimum sentence. That addict is not eligible for civil commitment.

But if the addict commits a nonnarcotic crime and does not have

a mandatory minimum sentence by statute, then the district attorney has a right or the prosecutor has a right to object to civil commitment. If the prosecutor without stated reason does not consent to civil commitment, the addict cannot be civilly committed. So, the prosecutor's consent is necessary to the nonnarcotic criminal.

Mr. ASHMORE. There is one other angle that I am not clear on, and I do not know what the outcome might be and I doubt if anybody does. I want your opinion. The defendant or the accused has certain rights.

Mr. KUH. Yes, sir.

Mr. ASHMORE. Suppose he gets a civil commitment, either by imposition or consent, and it is not successful and he is put in prison or whatever the court deems wise in the way of penalty. Then he claims that he has not been given a speedy or fair trial 12 months later or 2 years later.

Mr. KUH. This has not happened yet, Mr. Chairman. One thing I learned in the criminal law is that you never know what will happen tomorrow, no matter how ridiculous it may seem. I think the answer to that should be that the defendant who asks for repeated adjournments of his own trial, putting aside the civil commitment for the moment, just an addict who is charged with a crime, and who asks and obtains repeated adjournments, and his counsel is sick, his lawyer is sick, his lawyer is busy, we have hundreds of reasons. In New York any defendant charged with either a misdemeanor or felony for many, many years—I cannot tell you how long; long before Gideon was entitled to have a lawyer appointed for him—the defendant who has himself gotten adjournments has not been in any position then to say he has been denied a speedy trial.

Now we get back to the civil commitment practice. A person who is accused of addiction has had his rights read to him by the judge, as under our statute must be done. The judge must advise him of his rights. If he says, "No, I want civil commitment," then it seems to me this is equivalent to his having asked that his trial, if any, be adjourned.

Some ingenious lawyer may come in tomorrow and say when the addict went through this program for a year and a half and then fizzled and then was tried civilly, he was denied speedy trial. That may be the contention. I cannot imagine a court buying that contention. I do not know. It would seem to me a specious argument.

Mr. SHATTUCK. I want to return to your comment concerning the eligibility for commitment in connection with the chairman's remarks concerning the difference between a narcotic violator and a person accused of another crime. Is it not true that the Metcalf-Volker Act applies only to the narcotics violator specifically, and for that reason the prosecutor must agree because it would be more or less like an election not to prosecute or to proceed?

Mr. KUH. No. We considered this carefully in drafting Metcalf-Volker. There are two separate provisions. One is section 211 of the act, article 9 of the mental hygiene law, and the other is section 212. Section 211 is headed, "Proceedings Before a Court Concerning Defendants Arrested for Certain Narcotic Crimes," and 212 is "Proceedings of a Court Concerning Defendants Arrested for Nonnarcotic Crimes." The pattern of both is identical. The prime difference under

section 212 where the nonnarcotic crime is at issue is that the prosecutor has the veto power. Under section 211 there is no veto power.

Mr. SHATTUCK. Those bills failed to pick up this other provision under section 212?

Mr. KUH. Yes. I planned to touch on that. I prefer the broader treatment. We know and experience shows that the addict is likely not solely to further his addiction but, because of the whole nature of his personality—and this is closely tied in with addiction which is one manifestation of his personality—is likely to commit other crimes.

If you say you will civilly commit only a person who was caught with a bag of heroin in his possession but not the person who broke into my house in order to get a radio to hock in order to buy a bag of heroin, then you are making a major distinction all hinging on the moment that the addict was apprehended, whether you catch him 2 hours before he bought the bag doing what he had to to buy the bag, or you caught him 5 minutes after he bought the bag.

I think most people in police work and prosecution are agreed that virtually every addict, at least every heroin addict who ultimately at times will be arrested, does commit other nonnarcotic crimes, both to support his habit and as a result of his disturbed personality. I do not want to get into the psychiatric angle because I am not qualified on that, but this is our understanding.

If you make the distinction that Congressman Celler's bill makes and as the Kennedy and Javits proposals make, you are really making a distinction as to did you catch him at 2 p.m. or 4 p.m., and this, to us in New York, seemed an unfair distinction.

We think there is some merit to it and there is a need to deal with it. This is why we provide the prosecution veto in the nonnarcotic crime. Other than that, the civil commitment could be seized on as an escape hatch. A person committing burglary says, "No, I am an addict. Send me to the doctors for 3 months." If the prosecutor feels he has a real burglar, someone who is doing this substantially, he can say, "No, you are going to be treated as a burglar." This is the distinction we have.

I am getting a little ahead of myself.

One further remark, if I may, in answer to the chairman's question about have we a problem in bringing the addict to trial after he has lingered in the program for 2 years and then is found back in court. I have indicated that basically has not been a major problem and has not come up too often, but I would add one further thing to it. There are some of us in New York who are spoiling for legislation—I will propose it here in the Federal legislation—which will make it a new crime for the person who is under the civil commitment program either to escape from the hospital or to fail to report to aftercare. I do not know enough about Federal law, but many States have a crime of bail jumping and a similar crime of parole jumping. A person who is released on his own recognizance and fails to appear commits a new crime.

I suggest if we had this in New York and you had it in the Federal statute, this would give a very simple, almost mechanical way of convicting a person who fizzles in the program, because normally he fizzles not by not cooperating while remaining in the program, but by just stopping appearing for aftercare or escaping from the hospital. This is the prime sort of failures we get.

If you made that a new crime similar to bail jumping, similar to parole jumping, it would do two things: One, it would create leverage such that the person in the program would scratch his head a little bit before he jumped. He would know that he was committing a new crime. It would give him motivation to cooperate with the doctor. It would be something else hanging fire. Secondly, it would in most cases take care of your point, Mr. Chairman. You would then have a simple, almost mechanical way of convicting him. You would not need to get into whether it was heroin or the underlying crime at all. Did he disobey what in effect was the mandate of the court? If he did, he has committed a new crime.

We found that addicts were basically of two kinds—more accurately, a combination of two kinds. There are some addicts who sustained a real, genuine desire to get rid of their addiction. In terms of sustained desire that carries them over for months and months, I am afraid too few addicts have that sustained desire. Then we found that most addicts who were extremely street wise, wanted whatever program, either the election of civil commitment or the criminal proceeding, whichever program promised the minimum interference with their freedom. Hence, if we were to have a successful elective civil commitment program in lieu of criminal processing, two things were needed. The first was good inpatient facilities, a good inpatient program of adequate size to care for those arrested addicts who might elect it, certainly followed by an effective in-community aftercare program.

I might here say that whenever I talk of hospitalization, let it be understood I mean as an integral and important part of it, followed by a real aftercare program. Hospitalization without real close followup in the community is meaningless. All experience has proven that.

Mr. ASHMORE. While we are on that point, by hospitalization do you mean a particular type of hospital, or do you mean mental institutions of the various States?

Mr. KUH. I am pleased to answer that, Mr. Chairman. I do not mean necessarily a hospital. I do not mean beds in a ward that is all painted white. I mean doctors—and in this case the doctors will be really ruled by psychiatrists and psychologists since they are working with an inadequate personality—whatever they think most effective. In some cases this may mean beds. In others it may mean a work camp. In others it may mean some sort of industrial training school.

I think one of the problems and one of the criticisms that I and others have of the New York law is that we deliberately spoke, I think our term was of hospitals and facilities. The legislative history showed that by "facilities" we meant things other than hospital beds. Despite that, mental hygiene has just produced a limited number of hospital beds. We are disappointed that there are no farms or work camps and other facilities which at less cost would handle more and possibly better equip them to go back into life than they are equipped just being in a hospital.

So, I mean whatever facilities imaginative medical thinking can produce, not necessarily hospital beds.

Recognizing the addict frequently is weighing the lesser of two

evils and really does not want cure, another strong need was realistic judges who would help the addict to make the choice of civil commitment by making the alternative to civil commitment a very tough one, judges who would dole out sustained sentences to addicts who were not themselves interested in treating their illness. Such judges would help motivate the addicts and they would eliminate the revolving door aspect of the addict in the courts, and they would also serve to protect the community from the addict's depredations by removing the addict who had not sought medical supervision from the community for a sustained period of time.

That is our program. In practice, however, New York State's program proved defective. You have my prepared statement, and attached to it is a chart that analyzes the first year of the New York operation in New York County. I might say New York County is the island of Manhattan which is, unfortunately, the principal addict ghetto in this Nation. We have most of New York City's addiction. We have most of New York State's addiction. New York State is, sorrowfuly, first in the Nation's ranks of narcotic-prone areas. The chart shows the extent to which addicts elected hospitalization and what happened when they elected hospitalization.

Let me interject that I apologize to your committee that the chart I prepared was prepared in October of 1964, about 9 months ago, and analyzes our figures for 1963. I left the prosecutor's office in January 1965, so I have not since that October chart brought it up to date or been able to bring it up to date. Unfortunately, one of my criticisms of the operation in New York has been the abysmal way that our mental hygiene department has taken up its responsibilities. I point out that section 203 of the New York statute, which you have before you, spells out specifically that the mental hygiene department is to provide the public with education concerning addiction. That is in subsection (5).

Subsection (6) of section 203 provides that mental hygiene is to disseminate information about addiction.

Subsection (7) provides that it is to gather information and maintain statistics.

I have yet to see any publicly released statistics by our mental hygiene department, although they were saddled with this law on March 21, 1962—3½ years ago. So, with the lack of any statistics forthcoming from them, I have had to burden or at least try to help the committee with my own statistics which are not quite up to date. I apologize for that, but that may give some indication of why the New York law is not working as well as it might.

Mr. GILBERT. I have a question for information. What specifically is the type of information that you have reference to, to be disseminated?

Mr. KUH. There are many things in terms of education, collection of statistics, disseminating information. The statute provides relating to public and private services and facilities in the State available for the assistance of drug addicts and potential drug addicts. The education section provided education on the nature and results of drug addiction. Section (7), gather information and maintain statistical and other records relating to drug addiction and drug addicts in the State. It shall be the duty, and so forth.

Mr. Gilbert, what I had in mind at this particular point was that with the law having been in effect for 3½ years—the arrested addict part has been in effect since January 1, 1963—many of us would have hoped that by this time mental hygiene would have provided us with statistics somewhat similar to those that I have provided in the chart attached to my statement; namely, how many addicts have been eligible, how many have asked to go to facilities, how many have you accepted, how many have the courts turned down, of those you have accepted how many have completed the program and how many have walked out. These are things that would enable your committee and enable some of us in New York and enable the New York Legislature to judge mental hygiene's performance. These are factors that it was intended mental hygiene would keep and report.

Mr. Gilbert. In other words, statistics relative to narcotics traffic, and so forth.

Mr. Kuh. Really, several things. One, statistics and information about how mental hygiene is doing, what they are doing. Second, general statistics, the number of addicts in the State, whether or not mental hygiene has had contact with them. Is addiction growing or not. In what age groups is it growing or not growing.

Then part of the educational function—what about at least debating the question: Should you teach schoolkids about addiction, or does this make it tempting? We do not even know if mental hygiene has considered this debate. I know there are people on both sides of it. Some say show films similar to the Army VD films and let kids know what they face. Others say if you show them what they face, it may entice them.

I do not know. At least we ought to have a report which says, "We, mental hygiene, have considered this and this is what we have decided." We have no such report.

Mr. Gilbert. In New York City, some of the police department has sent out experts to lecture in junior high schools concerning the use of drugs and narcotics. I, myself, having a child attending the school, the first I knew about it was when my daughter told me somebody from the police department was in discussing the narcotic problem. These children range in age, I would say, from 11 to 14 or 15, at the top maybe 16.

I just wonder about the effect that this type of lecture would have upon the child. I think some study ought to be made of it.

Mr. Kuh. Others share your wonder about this. There are two schools. One, if you show it as it is, which is mighty grim, that this will deter people from it. The other school is that it may appeal to the braggadocio of some kids and encourage them. I do not know. The problem that I have is that mental hygiene has done nothing, nothing at all in terms of education, educating late teenagers or college kids, who we know experiment a good deal with marihuana and who should, hopefully, be receptive to some education. There have been no reports that I have seen.

Some of the people at mental hygiene have spoken at hearings like your own and I have seen their formal statements, but no reports to the public stating what the problem is. This is just one area in which I feel that mental hygiene has been given the ball and has not run with it.

Mr. GILBERT. I am interested in two aspects of the narcotics problem: basically, the aftercare of the narcotic user, and also the effect of narcotics upon children. I separate the narcotic problem into these two aspects. I know you are touching on these problems in your statement.

Mr. KUH. I think these are two areas that most concern the community. What is happening to the young folk and then when they get out of jail or the hospital, is it just a revolving door and are they back in? What happens when they go back to the community?

This is why, as I said before, I cannot stress strongly enough the importance of aftercare. A hospitalization program without real community followup means nothing. I do not want to turn this Washington forum into a tirade against New York, but in Manhattan where the addicts are, the aftercare program consists of two clinics. One is Manhattan State Hospital on Ward's Island which, as you know, is in the East River and accessible, I believe, by bridge or by boat. It is not in the addict community. The other is a small aftercare facility on East 18th to 19th Streets, miles away from where our real addict concentration is.

The need for an aftercare program is not to tell someone, "Please, Mister, come down and see us once a week and we will check that you have been here, and then you may go back home," but it is to be able to work with him. If suddenly at 4 in the afternoon he feels lost and wants someplace to go, you have people there or, in fact, if it is at 4 in the morning, some people who can help him and talk to him. Something like the East Harlem Protestant Parish, a volunteer group. They are open 24 hours a day and are there to help people.

You also need an aftercare unit that goes into the community after I have been released and spot checks me, uses chemical, urine chromatography, and finds out if I am secretly backsliding, talks to my neighbors and finds out what I am doing. This is the way that you really know what the addict is doing in the community.

Having an institution on an island does not do that. I think one reason for our failure in New York is that it has not been done.

Mr. GILBERT. We had a doctor testify last week before the committee, Dr. Baird, with whom I am sure you are familiar, who operates a clinic called, I believe, H.A.V.E.N. I do not know in what part of the city he is located. Are you familiar with this program?

Mr. KUH. I only know about it what I have read in the newspapers, but that has been a fair amount.

Mr. GILBERT. He made quite an impression on the members of the committee. At the same time, he took quite a slap at the State of New York, the city of New York, and all the agencies interested in the narcotics problem.

Amazingly enough, many of the things he said were very close to what you are saying here.

Mr. KUH. His work is a sort of group therapy to help them along. He has a problem. East Harlem Protestant Parish, not criticizing Dr. Baird, with much less fanfare has done the same thing, not exactly the same but in community service for years and years has done a fantastic job. This is what is needed.

It takes a little imagination to go beyond the black letter of the statute. What we have in mental hygiene is not even living up to the ack letter of the statute.

To give some of he figures, I point out that of 1,093 addicts who asked to be hospitalized in 1963, who were eligible for hospitalization, mental hygiene accepted only 615, turning down 43 percent. Here is a law designed to help addicts——

Mr. GILBERT. Is that due to lack of facilities?

Mr. KUH. They do not have to give the reasons. I think the prime reason is lack of facilities. Knowing they do not have adequate facilities, they then look at two addicts and decide which one they think—it is crystal gazing and guessing—is likely to be more successful. It primarily has been the lack of facilities.

Then when we get the addict in the facilities, their program has been to hold the addict about 90 days. President Kennedy had named an ad hoc Committee on Narcotic and Drug Abuse which submitted a report before President Kennedy's White House Conference in 1962, and they recommended that the minimum hospitalization period should be 5 months. I gather from Richard McGee, director of correctional institutions in California, that their average commitment—this is why they are successful—is 14 months. New York's is a 90-day program, and out in the street. I say 90 days without alluding to the fact that many addicts escape.

Here again, I think the New York Mental Hygiene Department has unfortunately not noticed, not observed, not taken cognizance of the fact that they have a public health responsibility. When an addict can just walk out of their institution, the public has not been protected.

Mr. GILBERT. I want to ask one question about this. Is there supposed to be a separate appropriation in the State of New York for this program, or does it fall under the general appropriation?

Mr. KUH. Mental hygiene has a general appropriation. Then the law was passed in 1962, and that year I think the mental hygiene budget was increased by some amount. I cannot give you that figure. Then in 1963 and 1964, they sought a major increase. I am not certain of the figures, Congressman Gilbert, but some increase in 1963; but in 1964 when everybody was budget conscious, they had a million dollars or so that they had asked for—I think it was a million—lopped off their budget. So, they had planned some significant increase in hospital beds in 1964 that was denied when their budget was cut down.

In 1965, they got almost $6 million just for their addiction program.

Mr. GILBERT. For the addiction program?

Mr. KUH. Yes.

Mr. GILBERT. Specifically set out for that?

Mr. KUH. Yes. I think that is the figure—$5,789,000 for the department of mental hygiene for narcotic administration, treatment, and research, for the fiscal year 1965–66. That is part of the Governor's budget.

Mr. GILBERT. Do you know whether they plan to open these?

Mr. KUH. I know they have 555 beds operating now or as of a month or two ago and they plan to increase it another 50 beds. They plan to open new postrelease facilities and aftercamp facilities in Queens, Bronx, and Brooklyn. I do not think they are open as yet, however.

I have been very critical of mental hygiene. I think now finally that may be moving on this whole program. The criticism is: (*a*) it took them so long to move; (*b*) many of the things that it needed are things that could have been done without money.

For instance, I pointed out the absurdity of having aftercamp facilities down on an island between 18th and 19th Streets.

I am not an authority on real estate but I venture there are storefronts that can be rented in the most rundown parts of Harlem, where unfortunately addiction is the greatest, for $100 to $150 a month, so for $1,000, or $1,800 a year, which is not a budgetary item, instead of having the aftercamp facilities on an island they could have had them in the community.

Let me point out here that the preamble to the Metcalf-Volker law passed in 1962 stated that it was then, March of 1962, imperative that a comprehensive program to combat the effects of the disease of drug addiction be developed and implemented through the combined and correlated efforts of Federal, State, local communities, and private individuals and organizations. The purpose of this article is to provide for such program and for unified direction of the efforts toward the ends described.

Then in the act, section 203(1) it provides that the State commissioner of mental hygiene is charged with the formulation of—

A comprehensive plan for the long-range development through the utilization of Federal, State, local and private resources of adequate services and facilities for the prevention and control of drug addiction—

Et cetera, et cetera.

I bring this in because formulating such a plan would not have required an extra x million dollars but it would require people in mental hygiene who have this responsibility to sit down and meet with Federal, State, and local people, get together and ask how it can be attacked. I have yet to see how a plan is formulated. They were given this responsibility 3½ years ago.

Though I think the additional funds will get them rolling and are needed, I think there is much they cannot sluff off with the excuse they do not have money. I think there was a lack of real drive.

I think possibly one of the problems was that they have an able chap but he is unaided.

The Metcalf-Volker law provided that there would be someone specifically working under the commission and charged with this program, but they envisioned a subdepartment on mental hygiene.

One man also running one of their hospital units cannot possibly at the same time be setting up work camps and drafting overall programs, so I think the failure was in the department not to take this seriously enough.

Mr. GILBERT. Don't you think there is also a lack of trained personnel in this field?

Mr. KUH. This is certainly one of the problems of the program. Yet California, with perhaps less than half the number of addicts as New York, somehow has trained personnel to handle 2,200 or so people in their hospital.

We have 550 hospital beds. Why is it that California can produce whatever trained personnel are needed overnight for larger numbers when they basically start with a smaller problem?

I am not qualified to talk in any detail about this, but I have heard Mr. Wood of California speak, and Mr. McGee talk. They have units of 60 people and group therapy within those units. This is great. This does take trained personnel and they have managed to do it.

In New York, and I have this third-hand, from the representatives of the legal aid society, I am told addicts get out to Manhattan State and sit in the dayroom. They have nothing to do.

I may be wrong. This is hearsay on hearsay, and I know that. I have yet to see mental hygiene come out with a report like Mr. Wood's on Mr. McGee's and say "This is what we are doing."

They say "It takes time to train people."

They are taking more time than California to handle fewer people and to do less with the fewer they have. I don't know how to be more emphatic than that.

Mr. GILBERT. I know the program in California has been very successful. The program in New York has been an abysmal failure.

Mr. KUH. I am proud enough of New York to think, and I hope I am not insulting a Californian, but there is no reason why New York can't do anything California can do.

Mr. GILBERT. I say we can do it a lot better, with all due respect.

Mr. KUH. There is just no reason why we can't.

Mr. GILBERT. I don't think we have paid enough attention to the problem. I think we have made a lot of sounds and used a lot of fancy words and passed nice legislation, and then it sets on the books.

I am proud as punch of the hearings we have here because it gives an opportunity to so many people like yourself interested in narcotics programs to have a forum and to express your opinions, and maybe the people in New York will pay heed to what is being said here and get on the ball.

Mr. KUH. I am appreciative of that, Congressman Gilbert. I am not only appreciative of it but prayerful.

One points out the weaknesses and then one is told that it takes time and makes excuses.

I point out that our State mental hygiene department is charged by law with the entire program in New York State, not simply its program but coordinating Federal funds, volunteer groups, city groups, a real coordinated program.

Not only have they not done anything but I think at this point you cannot expect a department that does not have a commissioner to run with the ball.

Sadly the State commissioner of mental hygiene passed away in the middle of December 1964. There is a deputy commissioner who has been acting commissioner ever since then.

Mr. GILBERT. Who is that?

Mr. KUH. I know his name but I can't think of it at the moment.

I don't know the deputy myself, and certainly this is not meant to criticize him, but a man who doesn't know if he is going to be running with the ball day after tomorrow, who doesn't know whose nose he will get out of joint if he does something when the commissionership is apparently still undecided, he cannot be realistic. He cannot do the aggressive job that a commissioner can do.

I know there are many things before the Governor and there are many reasons why the commissioner has not been appointed, but when you leave that job vacant for 8 months it is no wonder that mental hygiene is not working as fast and as effectively as it might have had there been a captain for the ship.

Mr. ASHMORE. Back on page 6 at the top of the page, the figures

are alarming to me. You use the same words. You say, "81 of the 615 committed New York County addicts—or 13 percent—escaped."

Were those escapees who were later arrested and returned to the hospital? Were they tried? What happened?

Mr. KUH. I cannot give you a breakdown. Our experience is that most addicts will repeatedly get into trouble with the law so that chances are that of that 13 percent, within 6 or 8 months some of them were not only back promptly but were rearrested.

Mr. ASHMORE. This is from an institution?

Mr. KUH. From inpatient care. They walked out of the institution. As you say, this is alarming and shocking.

In the Federal prison systems if you had 0.01 percent escape rate you folks and everybody and his brother would launch investigations about it.

Here you have a State agency which has the responsibility to the public who says when pressed with this "We are not cops. We are not correction people. We are there to deal with the addicts' mind to help him but we are not going to coerce anyone."

It seems to me they must recognize that though we trust the addict and entrust the addict to the doctor, the doctor has at this point the responsibiliy to the community as well as to the addict and he has the responsibility to run a high security institution.

I think as I mentioned we probably could use more camps. I think one must size up the particular addict and say "This one goes into high security institution. This one has been with us for 4 weeks. He is responsible. We can put him in a work camp."

Instead they are all at hospitals where apparently if one is dissatisfied he can just about walk out. The newspapers carry it and nobody is interested.

Mr. ASHMORE. They are not confined?

Mr. KUH. There is an element of confinement but apparently it is not very good security.

Mr. ASHMORE. The next statement you make:

The aftercare program is shockingly ineffective; of almost 500 addicts arrested in 1963 to be released to aftercare, 373, about 75 percent, disappeared from the program.

They disappeared after they were released to aftercare?

Mr. KUH. They stopped showing up.

Mr. ASHMORE. What was done with them?

Mr. KUH. I hope in all this I underscore it is the adminstration of the New York law and not the statute itself.

Basically what happens to them when they don't show, Mental Hygiene says "Shall we give them another week?" They know addicts do not keep appointments.

When he still has not shown they send a formal notice to the court and say "John Jones had eloped from our program and has therefore been discharged," and in effect, this is not their language, "he is your baby."

Mr. ASHMORE. Talking to the clerk of the court?

Mr. KUH. Yes. In effect they say they wash their hands of him.

The court then issues a bench warrant. We handle in New York County in excess of 60,000 criminal cases a year.

With 60,000 cases, quite apart from the addict problem, there is an appreciable number of bench warrants, those who do not show.

I think there are seven policemen now assigned to the court as the warrant squad. It is obvious they can do little other than process paper. They cannot look for all the people.

When you add another 373 you have another 373 pieces of paper to be processed.

In fact these addicts go back on drugs and are rearrested and brought back into court on a new charge.

Then it turns out that there is a bench warrant for them and there are two charges.

Some of us have suggested that the mental hygiene department should have—our statute provides—that they shall have the power of peace officers and can have within their own unit an effective peace officer squad which, when I disappear in the community, they have my alleged community address and can look for me and take me into custody and bring me back to the facility or bring me back to the court and say "We cannot handle him any more. He is your baby." They haven't such a facility.

Mr. ASHMORE. Who administers this aftercare program?

Mr. KUH. Mental Hygiene. They are charged with administering it. I put quotes there. They administer it in the sense that if the addict reports weekly, or however often he is supposed to report, they make a note he reports, and they talk to him and ask how is is doing but they don't follow him into the community.

Mr. ASHMORE. If he does not report do they look him up as though he violated parole?

Mr. KUH. I don't want to get into details on this, but I am a member of the mayor's Commission on Narcotic Drugs Addiction. We will be issuing a report in the next month or two which is in draft now. One of the things that concerns us is the very point that you make—Mental Hygiene washes its hands of it.

We think there should be a recovery unit within the department so they do not release a former addict until they are satisfied that his local address will be a valid address, not a phony address. They verified this. They verified some person the addict knows in the community. Maybe they verify it in terms of the addict getting a job.

Today they simply say "Too bad. He is your baby."

Mr. ASHMORE. The next sentence states:

Of all of the 615 addicts accepted into the mental hygiene facilities from New York County's 1963 arrests, only 88, or 15 percent, were still either hospitalized or in aftercare late in 1964.

Mr. KUH. Here we have a program basically a 3-year program. There is provision that certain misdemeanors will cause criminal charges dismissed against them in 1 year, and 4½ percent of the total was certified as having completed the program and discharged.

Mr. ASHMORE. This seems to me to be a total failure.

Mr. KUH. It is. I think what is basically a 3-year program, starting January 1, 1963, and by October of 1964, a little over a year and a half later, only this small percentage of the people are still in the program; it is shocking.

I talk strongly here, and I see a reflection of your various attitudes. I hope it is clear we are not talking about the statute, but we are talking about the way it is administered.

Mr. ASHMORE. Would you recommend changes in the statute? Is it all administrative failure?

Mr. KUH. I prepared some testimony for hearing in New York which took place on November 13. It goes into some of these defects in greater detail than my formal statement here. I will hand copies of that up to you.

In my recommendations this was a hearing by the New York State Senate Committee on Public Health. In my recommendations let me read the key recommendation which deals with your question, Mr. Chairman.

This is at page 6 of the statement:

> Firstly, I believe the State legislature should take steps to see that all four corners of the Metcalf-Volker Act are utilized and that pursuant thereto New York State rapidly develops an aggressive and large-scale program. I personally despair of seeing Mental Hygiene give real leadership. With more than 80,000 mental patient beds, it finds narcotic addiction as a tiny flea on a small tail of a large dog. High officials of that department have publicly stated that drug addiction is not as keen a problem in New York State as is alcoholism. This completely ignores the repercussions of addiction which far exceed those of alcoholism.
>
> I would urge that a division of narcotics and addiction control be set up within the executive department charged with utilizing the Metcalf-Volker Act to the fullest and the act be revised to lodge responsibility in that division rather than in the State department of mental hygiene.

In brief, I have in mind that they have a commissioner of narcotic control with the staff. Then that commissioner will say "OK, for the inpatient program you will handle that but you are to report to us. We want to know what you will do with him when you get him.

"In the outpatient program, State parole division comes in. Getting jobs, the State employment agency comes in."

You need somebody in the department with people to help him who has no responsibility other than helping the addict, coordinating this program.

I think in that framework the law we have, simply taking it out of mental hygiene and charging it to someone in the executive department, would be most workable.

Like everything else, the law is as strong or as week as the people charged with it. We need responsible people charged with it.

Mr. GILBERT. I am impressed with what you said except I would like you to interpret what you said there. As far as the initial program, intake, it would be administered by the mental hygiene department?

Mr. KUH. Yes.

Mr. GILBERT. Then in the outpatient aspect it would be administered by the narcotics control bureau, whatever you want to call it, within the executive department of the State. It would be patterned after and controlled by the parole system which we have within the State of New York.

Do you mean this would be the parole system which we have within the framework of the criminal courts?

Mr. KUH. I am afraid I spoke too quickly and too flippantly, if I may use that word.

I am basically suggesting that one person with an adequate staff be charged with the responsibility and he be able to call on all State facilities, or if the proper facilities do not exist to create needed facilities.

I simply mean to suggest that he might call on the State parole com-

mission either to help guide his hand in how to set up the program, or possibly lend trained workers, and possibly under some circumstances to administer some facets.

I know what disturbs you, I think. I would not want the parole to the outpatient narcotic addict treated as if he were a criminal.

Mr. GILBERT. I didn't think you meant that. That would destroy the effect of the program.

Mr. KUH. It certainly would. It would have to be separate, or I suggest there are many areas of expertise in many States, certainly a large State like New York. To have one department handling everything and things that they admit they are loath to do, don't want to do as parole people, I think that is folly.

This is by way of apology in part—this is a statement made after the fact.

In 1960, I mentioned we proposed this election system, or in 1961 it was defeated, shelved in the State senate.

Then a group of us got together and had a series of shirt sleeve discussions, and some of us in those discussions said this should be handled by a separate agency, along the lines I am now suggesting.

We were told that the efficiency people, whose guidance the Governor suggested, decided one should use existing agencies. The Governor took it up in his cabinet. The only existing agency that would handle it was mental hygiene.

We were told if we were to get any bill through it would have to be a bill which lodged all the responsibility in mental hygiene.

Many of us objected to it but these were the facts of life, and we relaxed and enjoyed it. I do not think it has worked out well.

As an alternative I suggested, and this is a weak alternative, that if the legislature and the Governor are not ready to take responsibility from the department of mental hygiene, at the least legislatively they should require an annual or semiannual report from the mental hygiene department spelling out in detail what it has done concerning each and every one of its powers spelled out in the 12 paragraphs of section 203 of the mental hygiene law.

Mr. GILBERT. They always have to file a report for the work they have done with the executive department. They would then distribute this to all interested people, including members of the legislature.

Mr. KUH. What I had in mind was an alternative. If they were compelled under the statute to file such a report to the legislature, fine. Unless there is a general statute I have yet to see——

Mr. GILBERT. I think every department files statistics as to the work they are doing.

Mr. KUH. They file in connection with the budgetary requirements. They file a general report. However, they have 80,000 mental patient beds and now 550 marcotic beds. In their overall report the narcotic portion is minimal.

What I suggested is that this section spells out 12 different areas where mental hygiene is to have the responsibility.

What I would like to see at the least is a separate legislative requirement that in each of those 12 areas they file a detailed report saying what they have done, what they plan to do.

I do not think this would be nearly as good as having a separate agency but at least it would put them on the spot and perhaps produce some effort.

Mr. McCLORY. Thoughts are occurring to me as I listen to the testimony. It strikes me that this is essentially a New York City problem. We have created in New York State a State law. We have transferred, perhaps appropriately and perhaps unwisely, authority to Albany and the State government, not only with respect to authorizing the program, but administering a program.

Your testimony indicates it is the administration of the program which is unsatisfactory. It seems to me possibly there is an indifference or a lack of interest or lack of knowledge and information as to the extent and seriousness of this program, and partly because of the statewide interest that the department of mental hygiene has.

I wonder in the consideration of this legislation whether or not the Federal Government, if it undertakes to do more than be merely advisory and conduct research, perhaps to provide grants and loans for carrying out a new program, is acting in the best interests of the particular areas where this narcotics problem is so serious.

Mr. KUH. I think that you are certainly right, that addiction is primarily a New York State and New York City problem. We do have some addiction in our other States and larger cities and even some in the suburbs which causes considerable alarm when "nice kids" suddenly turn up, having started with marihuana and then heroin.

One can understand and bemoan the fact that ghetto tensions and ghetto living create certain problems, but it is not limited to that. There are other areas of the State concerned.

In terms of the Federal program I think one of the problems is that the Federal Government always seems at least to have billions of dollars to deal in many, many areas. Dealing with addiction, especially if you are going to create substantial hospital or various other in-patient facilities, and then out-patient care where the follow-up workers, social workers, what have you, have small caseloads so they can really do a followup and not just sit at the desk and check somebody in once a week, if you are going to do this it is darned expensive. There is no way of doing it for just a couple dollars.

I think the Javits-Kennedy bills, the Celler bill, they provide substantial sums of money on a shared basis, splitting pursuant to a formula with the States. It does not assume Federal responsibility of the States problems for a moment. I think that would be an error. It encourages the States to get in there with real programs and do something.

I think everybody likes something for nothing. If New York State is told for every $1 it spends it will have $4—in that case it would encourage aggressive action in the State of New York. This is a major need in the State of New York.

Different areas have different problems. The problem of addiction in New York City, Chicago, Los Angeles, and Detroit are serious problems. Today I see both Houses have passed a bill on urban affairs, a Department of Urban Affairs. Urban areas have many problems, and one is the problem of addiction.

I think Federal help in this area without Federal Government assuming full responsibility but aiding local areas is a vital thing.

In 1961 Senator Keating and Senator Javits proposed bills along the same lines and were kind enough to ask me to confer with them. I was of some help there.

I was disappointed we couldn't get the program passed in 1961, 1962, 1963, or 1964. I strongly hope your recommendation would be favorable in 1965.

I have been criticizing the mental hygiene department. If I may I would like——

Mr. HUNGATE. Perhaps we should let the witness conclude.

Mr. KUH. I would like to be somewhat critical of the courts, also. Criticism of the courts is highly relevant because you have before you in both the Celler bill and the administration bill the question of whether to eliminate mandatory sentences.

I think a program of postarrest, preconviction commitment, hospitalization instead of criminal processing cannot work, cannot work on any major scale unless the alternative to it is tough, businesslike, not sadistic, but really tough treatment of the addict whose chooses to be processed criminally.

Most addicts do not want to get in with the psychiatrist. Addicts are persons who generally lack motivation. They are interested in self-indulgence.

If the alternative to the possibility of several years under medical care, nuisance of aftercare, if the alternative to that is a judge who will say "90 days" the addict will take the 90 days and have it done with, and for the next 3 years he is free.

If the alternative is suspended sentence he would prefer being processed in the criminal court and getting that.

If the alternative is a light probationary program without any incarceration of any kind, the addict wants his freedom and mingle with his cronies and indulge in drugs.

One of the reasons the New York program has failed is that our judges have to a large extent ignored it. I mean they have ignored it in the sense they do not tell the addict "Mister, either ask for commitment, which you will get, or I will give you the statutory limit" which for a misdemeanor is an indefinite sentence carrying up to 3 years' imprisonment, or a felony anywhere from a minmum of 3 years to 10 years.

Unfortunately, this is what we had in mind. I was invited to speak to the statewide judicial conference right after this bill passed. Many of our judges were there and I explained what we had in mind.

Judges were very complimentary and interested but within 2 weeks they forgot about it.

Our judges have not created the alternative as a real prison sentence, so the revolving door still exists. The merry-go-round still exists. I am afraid judges have to be criticized.

If a judge said, "Mister, you could have elected Metcalf-Volker. You didn't elect it. Under the statute I can give you an indefinite penitentiary sentence of 3 years and I am doing it."

With that the situation would be far better.

As I shall suggest in a moment, I would favor retention of the mandatory sentencing provisions which now exist in the Federal court.

I spent much time criticizing the mental hygiene department. I think it was necessary to do it because many of you are skeptical about New York's program and I am skeptical with the way it has worked out.

In the Federal system you deal with the Surgeon General, and from

my little knowledge of the Surgeon General's Office you are dealing with a horse of a completely different color.

The Surgeon General's Office has shown an interest in addiction for many years in connection with the hospitals at Lexington and Fort Worth.

Go back and I think my history is right—to the days of the Panama Canal the Surgeon General's Office dealt with public health problems, the problem of contagion. This is an orientation quite different from the mental hygiene orientation.

I think charging the Surgeon General's Office with the civil commitment program you are extremely unlikely to have the problems that we have had in New York.

I think possibly by way of insurance, and also because I think it would be extremely valuable to the Congress, it would be desirable to include in whatever bill you recommend a provision requiring the Surgeon General to make semiannual or annual reports to the Congress specifically about the work that has been done with the addict. Have them indicate what facilities are created and utilized, numbers of persons found to be addicted, those who have been committed, length of the commitment, nature of aftercare, number of addicts to escape, failure to report for aftercare, numbers reporting back to the courts for further criminal processing, and the numbers to successfully complete the pogram.

I think such reports would help Congress.

One mode of assisting the Surgeon General in keeping addicts in the commitment program might be provided were the new legislation to make it a Federal crime—one analogous to "escape" or to "bail jumping" for a committed addict to escape from the Surgeon General's custody, or to fail without excuse to report to an aftercare program when required or within a stated number of days thereafter.

This would create leverage to motivate the addict and it would be helpful to the Surgeon General in keeping addict in the program.

Now we are in the problem of mandatory sentences. One of the nagging criticisms many members would have——

Mr. ASHMORE. Would you mind an interruption?

Mr. HOFFMANN. Assuming it was a crime for failure to report during aftercare and tied in with the present escape and parole restriction, would there be a built-in bumper in terms of the discretion already in the law?

Mr. KUH. You would have the same discretion as happens in New York State and other jurisdictions, where bail jumping, parole jumping are crimes. Frequently if the defendant takes a plea we do not prosecute. That area of discretion would be some buffer.

On the other hand the nice thing about the bail jumping structure is that if the witnesses have disappeared, or let us say it is a narcotics crime and you may be faced with that problem, you can say "Forget that. We will prosecute you for the jumping crime." It does create an election to the prosecutor. It gives leverage to keep the addict in the program and might make the prosecutor's job easier.

I think it would be good. The problem is that the addict lacks motivation and we have to artificially stimulate motivation.

One way of stimulating it is to say "OK, Mister, you can walk out of this program but if you do this is what you will face."

The hope is that motivation——

Mr. HOFFMANN. How about the mechanical problem of drafting the discretionary limits within a penal statute? My comment is that I do not think you would need it.

Mr. KUH. If you draft the statute saying that you create the crime of failure to abide by the Surgeon General's program—call it what you will—if you create a new statutory crime, the prosecutor has inherent discretion as to whether or not the prosecutor will take a lesser plea or dismiss the charges, I don't think the new statute would have to spell out standards of that sort.

One of the nagging criticisms against existing Federal law centers on the imprisonment of certain drug offenders that is now mandated. They must give certain sentences. Ordinarily those mandates are undesirable. But if you recommend something like the administration bill or the Celler bill, then for the first few years, until you have a chance to observe the working of the bill, it would be desirable to continue the mandatory sentences without any change in them.

This again creates leverage. This tells the defendant that if he wants to say, "This is all because of my addiction," fine, then he elects hospital commitment. That would be an exception to the mandatory sentence in itself.

If the addict does not elect hospital commitment it would not give him another alternate easy path, probation, parole, release, or 60 days.

If you create a real alternative, either illness or he will be kept out of the community, then you motivate addicts to make the election.

Mr. HOFFMANN. Will you comment on the statements you have just made in terms of the maximum with regard to the marihuana statutes? The proposal is to modify the existing structure with regard to marihuana.

Mr. KUH. In the Metcalf-Volker bill we specify that a person charged with marihuana possession, sale, and so on, is not eligible, marihuana itself not being an addictive drug. It does not make him a person who thereby can elect civil commitment.

He can elect it as a nonnarcotic crime.

This may be a personal recommendation, but I would say a person picked up with marihuana, in the first sale of marihuana, I personally do not think he should face the mandatory minimum; marihuana being a "horse of a different color" from heroin. It does frequently lead to heroin use, but we know there are large portions of people who will use marihuana over a period of years with some frequency and never switch to heroin.

I smile when I say this because I had an extortion case where police were shaking down a marihuana user who happened to be fairly wealthy and used marihuana for years. The marihuana user was a brilliant man, an excellent witness, and tried to sell me on trying the stuff.

He said "It is harmless. It is wonderful. Try it."

I last heard he was out on Synanon, got on heroin. He used marihuana probably for 10 years or so before he was tried; never touched heroin up to that time. He was convinced he never would touch heroin, and apparently something happened and he, too, got on heroin. So

there is some danger. I don't think you can laugh at it. I personally would not favor mandatory minimum sentences for marihuana use.

I have made the point as best I can as to the need for a tough alternative to hospital commitment. You now have the tough alternative in the present Federal law and I would not favor its modification.

I suggest one change in both the Celler and the administration proposals. Neither Congressman Celler's proposal nor the administration proposal provides for any humane effort to detoxify the addict, or to examine him medically to see if he is addicted, unless he has not only been in court and has there been notified of his right to elect civil commitment. This may be some days after his arrest. By that time indicia of his drug habit may no longer be clear to examining physicians.

We have found, for instance, in New York that the last few years the habits that our addicts have are thinner than they were 4 or 5 years ago. The amount of heroin they get in a small bag is less than it was a few years ago.

We found during the recent drug shortage that addicts were kicking the streets. They were without hospital commitment, without getting violently sick. There were no drugs and they stopped using them until they were available again.

I think when you are dealing with this sort of an addicted person and you do not get him to be examined medically until 5 or 6 days after he has been arrested the doctors will be judging his addiction largely by the needle marks on his body and by the defendant's own statements.

On the other hand if you get him as soon as he is arrested and see any signs of discomfort you are in better shape to judge whether, in fact, he is addicted.

The New York statute provides for a cross-examination.

I might also point out that the administration bill covers persons arrested for nonnarcotic crimes. You could get a situation where a person arrested for that type of crime might prefer being in the Surgeon General's care and, even though he had not been addicted, if as is permitted in either Congressman Celler's bill or the administration bill, if he is released on bail and then 4 days later says, "Yes, I am an addict. I want the Surgeon General's care," he might—and this is not completely ridiculous—he might in the interim, to make himself eligible, have tried a little bit of heroin, even though he never used it before.

I suggest to you that permitting the addict out, permitting the person after he has been bailed to make the selection, can befuddle the question.

New York statute 210 provides for prompt examination for purposes of determining addiction of all persons who have been lodged in detention facilities and who either show signs of addiction or who, having been arrested on drug charges, either request or do not object to such examination.

Humane detoxification, when medically indicated, is to be promptly commenced. Under the New York law, while under such medical treatment, the defendant is not to be admitted to bail.

This program does not deprive the defendant of any statutory right to bail he might otherwise enjoy. He is free to decline such medical examination for addiction; in that case he may be promptly bailed. Once he is released on bail he would be barred from a civil commitment rogram.

I point out it is the court which sets bail and at the time the court sets bail the court would advise him of his rights under the law and advise him that if he, in fact, is bailed he cannot later elect civil commitment.

The New York statute thus accomplishes several things not done by either the administration's bill or Congressman Celler's proposal.

It provides for prompt and humane detoxification for arrested addicts. Second, it provides a more reliable basis for ascertaining whether or not the defendant was addicted at the time of arrest than would exist if the examination were to be delayed several days.

Third, it minimizes the likelihood that the nonaddict defendant may "tamper" with his status as a prelude to making his election in order to avoid criminal penalties.

Fourth—and this is important—by keeping the addict institutionalized and under some medical supervision from his arrest until he has made the election the courts may be certain that in electing the addict was not under such drug influence as to be incapable of a freely made choice.

If you look at the bailed addict who is an addict, let us assume, he knows he is about to be sent into the care of doctors, so the day he is to make the election he shoots up at home, goes to the court, and says "I want the Surgeon General's program."

Let us say he fails that program, is charged later. Doesn't he then say "My election was not valid because I was under the influence of drugs." The air is cloudy. Aren't you better off if you kept him in custody during this time? You would have correctional facilities. They know by the time he makes the election he is clean and you cannot have the claim that he made it with his mind befogged by drugs.

To comment specifically on suggested changes in the administration bill, H.R. 9167.

That bill wisely permits civil commitment in lieu of prosecution not only for persons arrested for narcotic crimes but for addicts arrested for certain other crimes as well. I wish Congressman Celler's bill and the Javits-Kennedy bills were similarly expanded. The Attorney General indicated that 43 percent of all convicted addicts in Federal institutions are there for nonnarcotic violations. I have no exact local figures in terms of people institutionalized but the police issued a figure within the last year that 49 percent of our defendants were arrested for misdemeanors.

The police ask whether they have used narcotic drugs. This is not for the purpose of using it against them. Forty-nine percent of the New York City misdemeanors admit to having used narcotic drugs. About 13 percent of those in New York City arrested for felonies admit to having narcotic drugs. The New York experience is somewhat similar to the Attorney General's experience.

Mr. HOFFMANN. You said 49 percent used drugs at one time. To what extent is that used? Is it one day?

Mr. KUH. I cannot answer because you have a whole spectrum there. There are such things as weekend users. There are such things as people who have "once-for-kicks use."

In talking about heroin addiction is something relative. I pointed out the problem of the shortage and everybody clamoring to get into hospital beds for withdrawal.

Now people don't clamor. They can withdraw on the streets. This is all an uncertain dividing line. What I am saying is that I cannot answer and don't really think anybody can give you an answer. The dividing line between a user and an addict is a shadow area and not a clear area.

Mr. ASHMORE. In most cases does not a user become an addict?

Mr. KUH. In most cases he becomes addicted to some extent. As drugs get into scarce supply the dosages they may get might be lighter.

On the other hand there is the addict's craving.

Mr. ASHMORE. The system demands more as he uses it?

Mr. KUH. Yes, sir.

I have one quarrel with the administration bill. I do not know why the administration bill excludes the crimes of burglary and housebreaking which are essentially crimes against property, not persons, and commonly are committed by addicts. If you have a burglary and housebreaking accompanied with any violence then it turns into an assault or robbery. The robbery certainly would be excluded. It seems to me that as is true in the New York statute, the burglar and housebreaker can be considered for civil commitment in lieu of criminal proceeding.

In terms of the nonnarcotic crime I am talking about included within the Attorney General's bill, it seems to me the exclusions that the Attorney General's bill provide seem sound. You don't want the nonnarcotic criminal to use civil commitment as an escape hatch.

I also would add to those exclusions, as I indicated earlier, a veto by the prosecutor.

When we get to the narcotic crimes I would agree with Congressman Celler, and this frankly is not the law in New York, but I am not sure that the person arrested for narcotic crime should have the various exclusions.

I know I said before the difference between the arrest between one crime and the other is basically a matter of time. Yet it seems to me if the only thing you can prove against the defendant, if you can prove it, is that he possessed a packet of heroin, and it turns out he is in fact addicted, I am not sure it is sound to say that you will not permit him to elect civil commitment because he has a prior felony or two prior felonies.

I have some doubt but I am convinced it is not sound to exclude him from civil commitment simply because he has unsuccessfully on two prior occasions failed in civil commitment. That is the law in New York.

I know the administration bill has a similar provision. It is the medical experience involved here, and here I am talking with a hat I am not entitled to wear, but I am told medical experience indicates frequently a person who has tried civil commitment once, twice, three times, been unsuccessful, as he matures each time he tries and tries again he may well succeed on the fifth effort where he failed on the first.

To exclude a person solely because on two or three prior occasions he has tried civil commitment and failed, I understand it is medically unsound. I would eliminate that exclusion from the Attorney General's bill and would like to see it eliminated from this bill.

Mr. SHATTUCK. I believe the point is this: An individual would have a 3-year period under the administration bill and this would be after he had a prior experience under a State program, but this would be limited.

Mr. KUH. I am not sure I follow you. Doesn't the administration bill provide that if a person has twice previously—well, suppose——

Mr. SHATTUCK. I understand that. When they say "failed of civil commitment" this means it is an individual who has gone through the entire period. He has done it hopefully.

Mr. KUH. Hopefully.

Mr. SHATTUCK. This is recognition of a point you have made. We must expect there would be failures, that is, that he will not comply. He will relapse to using the drug, perhaps.

Mr. KUH. Take the administration bill and I am arrested for a Federal narcotic crime. In the first month at the hospital I escape or tell doctors to go to blazes and for some reason they feel I am a failure. They send me back to the criminal courts.

Mr. SHATTUCK. That is the point I make. The mere fact he is not successful at some point in the program does not necessarily mean he is unsuccessful in the aftercare program as a whole.

The fact he has relapsed or does not progress as quickly as he might does not mean that he has to be sent back to court and be committed.

Mr. KUH. I understand. The Surgeon General can do this. He could under either bill take me back again, put me in the hospital, and would not have to say that I have failed and I have to go back to the court. The Surgeon General can play this by ear.

Mr. SHATTUCK. Emphasis should not be placed on the fact he does not come in at a precise time.

Mr. KUH. I agree. You need a cushion.

Mr. SHATTUCK. I think it does imply a substantial compliance and a willingness to go along with the program.

Mr. KUH. Right.

Mr. SHATTUCK. We would not try to equate this with the person who just leaves and escapes, elopes, whatever the term is, and just does not comply with the program we are contemplating here.

I don't know how we can completely resolve this question. We would appreciate any comments you might have as to what we mean when we say, "Failed of civil commitment on previous occasions."

I think we are thinking about a man who has gone through a 3-year program for civil commitment and has not obviously had the required results.

Mr. KUH. I would hope what is meant is this: You mean this in terms of completely separate arrests. In other words, I am arrested in 1964. I am released to aftercare. I fail to appear, but the Surgeon General or the mental hygiene department says, "We will not bounce you back to the courts. We will continue to work with you."

That would still be just one civil commitment. As long as I am kept in that program it would be just one commitment even though I may be back three or four times.

Especially at first when the Surgeon General's facilities are likely to be somewhat limited there might be a limitation on how often they bounce me back and forth.

I am guessing here and crystal gazing but it seems to me at least the condition may exist where for some reason or another the Surgeon

General is impatient with me and throws me out of the program because of my own failures, and throws me out of it fairly promptly.

Then I am processed in the criminal courts and either convicted or acquitted. That would be one civil commitment.

I can imagine a situation where this might happen to a person on two or more occasions and yet the third time around that person still might be a good risk.

I do not see the need, therefore, of saying a person will be excluded. I do not see the wisdom of excluding him because there have been two prior units, if you will, of civil commitment.

This is a subject of judgment and I certainly understand that reasonable men differ. I would agree with Congressman Celler's view.

Mr. HOFFMAN. Would you consider substituting for this provision a veto by the Surgeon General, giving him absolute veto if he considered he needed more time?

Mr. KUH. I think in one bill, in effect he has a veto. I forget the exact language, but he has to find not only the addict is addicted but suitable, and that is, in effect, a veto in the one bill. I do not know that the other bill has that provision.

Mr. HOFFMAN. The one we are working on does not.

Mr. KUH. Of necessity, simply because the Surgeon General may not have facilities enough, I think the Surgeon General must be given some election. I know I was disturbed about this when we gave mental hygiene the absolute veto in New York. They vetoed 43 percent of the people, as I said. Yet you cannot set up beds, aftercare trained people, everything overnight.

Also, economically you cannot set up facilities larger than are needed in the thought we therefore will always be able to handle everyone. You need some restraint on the facilities, which means invariably some people will be turned down.

I think the Surgeon General must be able to consider his bed capacity and his outpatient capacity and have some veto.

Section 102(b) of the Attorney General's bill does not permit a defendant to contest a finding that he is not addicted. The New York statute does give the defendant who wishes to contest such a finding the right to a hearing. That is in subdivisions (4) of both sections 211 and 212 of our New York law. I might say such hearings are rarely, if ever, requested. I say rarely, if ever. I know of no request, but there may have been some.

I think having a provision for the hearing will not prove burdensome in practice, and as it is the difference or may be the difference between a finding of addiction or nonaddiction and may mean either medical custody or the alternative of mandatory lengthy incarceration, it would seem to me the more enlightened course and safer course and possibly the constitutionally prefreable course to permit such a hearing.

Now to comment specifically on Congressman Celler's bill, H.R. 9051, I have indicated that I would be happier with that broadened to include nonaddiction crimes. I also am troubled by what seems to me a slight inconsistency in wording. Section 3814 of the Celler bill provides for the dismissal of criminal charges once the Surgeon General certifies that the defendant "has successfully completed his probationary aftercare treatment program." I think that is a good stand-

ard because I am not quite sure what it means. The doctors cannot be tied down to saying somebody has been cured. They are never sure anybody is cured. Basically we are saying this is a problem for the doctors to handle, and when you say "has successfully completed" you are saying, "Doctor, this is your baby. You tell us when it is successful."

Then you get into section 3813 of the Celler bill and it has some language which specifies determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs. Other than talking about the person who because of his inpatient status has been physically removed, I do not think you will find doctors who will want to certify that anybody has been effectively removed. That language bothers me because I think it would bother the doctors. I think they would tell you this is a degree of crystal gazing and we think somebody is removed or there is great indicia of good prognosis and, lo and behold, he is back on drugs the day after he is released. I advise a change in that language.

The Celler bill does talk in terms of probationary aftercare treatment, but it fails to specify, as to both the New York statute and the administration bill, that during such treatment the released defendant, and I quote the administration bill, "shall be subject to home visits and to such physical examination and reasonable regulation of his conduct as the supervisory aftercare authority establishes." That express provision is desirable so that it will be clear at the time the defendant elects civil commitment, to be followed by aftercare, that thereafter during the aftercare period he has subjected himself to spot checks and at least to some extent has waived the protections with which he might be cloaked by the fourth and fifth amendments to the U.S. Constitution.

I point out that to have effective spot checks you should be able to appear suddenly at the defendant's home, not because you have prior information that he is back on drugs, but because you know that prognosis of the released addict is not good. Two out of three will probably be back on drugs. So you should be able to appear at his home and get a urine specimen and check for his present status without going before a judge and getting any sort of search warrant.

I think you insure the right to do it when in effect you warn the defendant of that at the time he makes the election.

As I read the Celler bill, there was no such provision. The New York statute spells out such a provision. I will not take the time to find it now. I will point it out to counsel later. The New York statute does spell out that the addict agrees or recognizes that he is subject to the use of Nalline or other narcotic antagonists or other tests. This has not been tested and I think it probably has not been tested because it is so clear that we yet haven't gotten a lawyer to go off half cocked and take the time to test it, but this in effect is telling the defendant that when you make your selection, you are getting certain benefits. You are also exposing yourself to certain restrictions that your neighbor who has never been arrested and never made this election is not exposed to. One of the restrictions is a sort of quasi-parole status such that the "parole officers" can visit you in your home and make certain tests.

I think if you spell this out in the statute and spell it out in the warning when he elects, you are at least safer, on surer ground if it is tested out in the courts than if you simply said, sure, it was implied that we could do this. Why not put it in the statute?

Mr. SHATTUCK. In your mind, this would mean that when the investigator came to the house and he was met at the door, he would be admitted?

Mr. KUH. Yes.

Mr. SHATTUCK. It was agreed as part of the treatment program that the man would be admitted and that he would be cooperated with and the penalty for not cooperating would be, of course, violation of the treatment program.

Mr. KUH. Yes. I am sorry I cannot cite the case, a lower New York case opinion that I find appealing concerning a defendant who was visited in his home by his parole officer who there found further contraband. I do not remember whether it was a narcotics or what sort of case. He came into court and said the parole officer was an agent of the government and had no search warrant. I have now not only been charged with parole violation, but also with the new crime of possession of narcotics or dirty pictures, or whatever it was. The contraband was found pursuant to an illegal search, a search without a warrant, and so forth.

The court rejected the motion to suppress, saying the parole officer had every right to make the home visit without making a showing before a judge that he had reason to believe there was a crime, that he was pursuing his legal duty, he was in your home lawfully, made a search lawfully, found you now committing a new contraband crime, and hence the seizure and the arrest become lawful.

I know of no appellate cases on that point. Probably there are some in some jurisdictions.

It seems to me you at least give yourself firmer ground argumentatively if you let the addict know at the moment he makes the election that he is restricting his own future rights somewhat.

Mr. HOFFMANN. When he agrees to a commitment for 3 years, is he not contemplating commitment in a hospital and confinement for 3 years? If you put a man in prison and then you parole him, normally there are conditions attached to his parole pro forma. One of these is if the case is given to the parole officer, the parole officer will visit him and he is to receive the visit. Is that a reasonable parallel here?

Mr. KUH. I think so.

Mr. HOFFMANN. Again, I am wondering from the drafting point of view, do you think it requires that we encumber the Federal statute with such an essentially housekeeping provision?

Mr. KUH. I think your argument is a sound one, Mr. Hoffman. If the defendant can be held a maximum of 3 years and from his angle you are doing something less, you are giving him something he is not entitled to, you should be able to condition that and condition it without spelling it out in the statute.

On the other hand, you can anticipate this is something that is likely to come up often, because I envision real aftercare, not the kind we have in New York but real aftercare being replete with spot checks, this not just happening once in a blue moon, but everyone under aftercare from time to time will suddenly find somebody checking him.

This, it seems to me, is necessary to aftercare. If you are to have this, invariably somebody sometime is going to be caught redhanded and will make some attack on the legitimacy of it.

The language we have in here, which I will be able to find later, is simple and does not complicate or encumber the bill. Why not anticipate it and include it in your bill?

If it meant four more paragraphs spelling out details, I would agree with you; but it simply says in substance that the defendant recognizes and agrees that he will be subject to aftercare supervision that may include various approved medical tests and procedures, or visits, or something to that effect. I can certainly see your argument, but it seems to me this is one area where you can do it simply, and why not play it cold?

I stated before, I think in answer to Congressman Gilbert's question—maybe it was Congressman McClory's question—how important it is that there be Federal aid to the States in their programs dealing with addiction. It is in the Celler bill and it is in the Javits and Kennedy bill. I am certainly all in favor of that.

In concluding, I might say that when in 1962 New York enacted the Metcalf-Volker law, many of us hoped that it would light the way to a new penology, a penology that would encourage persons charged with certain crimes, whose antisocial acts were clearly the products of certain marked personality defects, to take the initiative in furthering their own rehabilitation with medical assistance outside of our traditional court-correctional structure. Had this worked with addicts, it might have been adapted for alcoholics, for sex criminals, for compulsive shoplifters, and others. The Federal interest in a civil commitment program in lieu of criminal proceeding as in the two bills before you gives evidence that Congress now has the chance to take up the torch of leadership that New York for too long has been fumbling so poorly.

I might say I have a clipping from this morning's New York Times reporting on the conference in Stockholm, attended, I understand, by your colleague, Congressman Carleton King, who I knew when he was the very excellent district attorney of Saratoga County and president of our State DA association. The chief U.S. representative at that conference is Solicitor General-designate Thurgood Marshall. He is quoted in today's Times as saying the United States, along with many other countries, is engaged, quoting now, "in an attempt to explore new treatment to defenders which will fairly reflect society's interest in protecting itself and yet will provide the maximum opportunity for an individual to turn away from crime."

It seems to me the election of civil commitment in lieu of criminal procedures is precisely along the lines of what Thurgood Marshall has asked for in the Stockholm Conference.

I think congressional legislation will do more than deal with Federal addict prisoners. By example generally, and specifically by provisions of Congressman Celler's bill and the like bills introduced in the U.S. Senate by Senators Jacob K. Javits and Robert F. Kennedy, with the co-sponsorship of other Senators, the States will through this legislation have their own efforts to aid the addict further.

Tragically, in our major cities, drug use is disproportionately a failing, an escape, for our ghettoed masses, for our minorities—Mexi-

can, Negro, and Puerto Rican. The burden of such disproportionate addiction is just one more shackle, one more chain that enslaves these minorities. Congressional action to strike that chain will be another major gain for the oppressed, particularly in America's heavily populated northern and western cities.

That is the end of my formal statement.

Mr. ASHMORE. Let us all make our questions as brief as possible.

Mr. HUNGATE. Mr. Chairman, I would not want to miss the opportunity to congratulate Mr. Kuh for his lucid, informative, and comprehensive analysis of this entire field and the proposed legislation, although perhaps this should be expected from a graduate of the law school with the gold medal class of 1948.

Mr. Kuh, I would like to ask you about nonnarcotics offenses when someone comes in and pleads he is an addict. Is there discretion in the prosecuting attorney as to whether or not he is so treated?

Mr. KUH. Yes; the prosecuting attorney under the New York law has absolute veto. He does not need to explain it or state his reasons. He has the veto power of excluding the addict who is arrested for a nonnarcotic crime.

Mr. HUNGATE. Would the judge have the veto power?

Mr. KUH. The judge would have in the interest of justice. As I say, that has rarely been done.

I might point out one wrinkle on that. The New York statute, apart from its precriminal processing election, does permit the judge at the time of sentence to send the addict to a mental hygiene facility. It is rarely done, virtually never done. But if the DA vetoed the addict's consideration, the addict who is arrested for burglary, let us say, and the DA says, "No, I want him convicted of burglary," still the judge at the time of sentence, instead of sending him to Sing Sing, our State prison, can say, "I will send you to a mental hygiene facility."

Mr. HUNGATE. In a sense, that is expressing an element of decision. What is your view of the propriety of that discretion also existing in the district attorney or States attorney?

Mr. KUH. I think when you are dealing with a nonnarcotic crime, the DA should be able to say or at least to reason to himself that this was a dangerous crime, a sizable crime. Let us say it was a burglary, stealing jewels worth $100,000. This is clearly a burglary far beyond the addict's need to support his $10-a-day habit. The DA should be able to say, "I want this man to be convicted of burglary."

Mr. HUNGATE. Nonetheless, if he determined under this statute that the man was an addict and the Surgeon General determined he might still be subject to rehabilitation, could he still be given treatment?

Mr. KUH. Under the New York statute he could. This is not in your present two drafts, but under the New York statute he could still be treated, but he would be left with a criminal conviction of burglary. He would have that conviction on his record. Instead of going to a State prison, he could well be sent to a mental hygiene facility.

Mr. HUNGATE. Do I understand it is your position that it is better not to require a plea of guilty, as I understand is done in California, but to proceed, and you do not see a substantial danger in the fact that a man might be in this program for 2 years and then fail, and then when you went to prosecute him for the original crime perhaps the witnesses would be gone?

Mr. KUH. I have indicated I do not think that is a substantial danger; and I think for what danger exists, at least part of the slack would be taken out if you created the new crime of failure to appear. I do not mean to be critical of the very excellent and really fantastic correction department in California, but I know Richard McGee, and I have spoken to him about it, and they see it through their eyes when they get the defendant after the criminal court processes are completed.

I do not know if your committee has heard or spoken to any California prosecutors. In other words, when I talk to Dick McGee, he generally says they all plead guilty. I do not know that he is wrong. I have not discussed it with California prosecutors, but I know from New York experience and from problems of suppression and problems now of excluding confessions as in *Escabedo*, more and more cases are going to trial. I have difficulty guessing that people are pleading like mad because they want to go to the California addict facility. I suspect the prosecutors still find a large number of the cases are aging, delayed in process, and correction sees it simply in terms of a defendant who very quickly pleaded guilty and was tried. The DA has him for months and months while those cases are aging.

Mr. HUNGATE. Does New York have a mandatory minimum for narcotics offenses?

Mr. KUH. It does and it doesn't. For narcotics felons there are mandatory minimums of 3 years for possession of a certain amount, 5 years for possession with intent to sell or actual sale. If there is a lesser plea to an attempt of either of those crimes, the mandatory minimum is cut in half. So, the mandatory minimum for a narcotics seller, first offender, in New York is a year and a half, which would be for the crime of attempted felonious possession. There is no mandatory minimum for the narcotic misdemeanor unless he is a multiple offender. A person on his first conviction of possession of a small amount of heroin faces no mandatory minimum.

Mr. HUNGATE. It carries a sentence of under 3 years and would not necessarily receive the mandatory minimum sentence?

Mr. KUH. Ordinarily not. This gets into the complication of sentencing. The narcotic misdemeanor who would ordinarily face a maximum sentence of 1 year and then with a special wrinkle we have could face a penitentiary sentence of up to 3 years, would not ordinarily face any mandatory minimum unless it was his second narcotic conviction, in which case there would be a mandatory minimum of 6 months.

Mr. HUNGATE. If it were not his second offense on a narcotics misdemeanor, he could receive a suspended sentence?

Mr. KUH. He could. I do not have the figures here. It would be my guess that 95 percent—I do not think I am overstating it—of the first narcotics misdemeanors get suspended sentences. I think this is the absurdity of our merry-go-round. The judges know they are going to be back. The addict knows he is going to get a suspended sentence, so why should he elect the Metcalf-Volker bill where he could be under supervision for 3 years? He is processed in the courts and he ends up with a suspended sentence. There is nothing to drive him into the arms of the doctor.

Mr. HUNGATE. Is it typical in New York for the narcotics felon to receive suspended sentence?

Mr. KUH. Yes, it is. I am glad you asked that. There are these mandatory minimums for felons, but the courts have held that the mandatory requirements do not require the imposition of sentence. In other words, the judge can give a person 3 to 10 mandatory, minimum up to the maximum, and suspend the execution, and they still do on occasion, with felons.

Mr. HUNGATE. As I understand your position from your experience with this and your study of the problem in New York, you think these mandatory minimums should be imposed, should be required?

Mr. KUH. I think the best thing would be to have hospitalization as the only alternative to mandatory minimum sentence, and then this forces the addict to make the real choice. If he says, "I am sick, treat me as sick," fine. He goes that way. If not, he really goes to jail and no longer endangers the community for a stated period.

Mr. ASHMORE. He goes to jail or the hospital, and he is likely to take the hospital.

Mr. KUH. I suspect he would, because the addict is the streetwise or savvy guy. His buddies have been out and he knows what he faces.

Mr. HUNGATE. Do I understand you favor the broader provisions of the administration bill as covering not simply those who are convicted of narcotics-connected offenses, but also if they are addicts connected with other offenses?

Mr. KUH. Yes; I do.

Mr. HUNGATE. You would in fact think it might be well to consider expanding it to burglary and housebreaking if they are addicts?

Mr. KUH. Yes. I do not understand the thinking that eliminated burglary and housebreaking. I have not discussed this with anybody at the Justice Department. To me, it makes no sense, because so many addicts do not commit crimes against person, but do commit property crimes to support their habit.

Mr. HUNGATE. In your judgment, the fact of prior conviction of a felony should not automatically deprive one of being eligible to the benefits of this treatment under the law?

Mr. KUH. This is a subjective thing. I would think, at least insofar as we are dealing with a person arrested for a narcotic crime. If he is arrested for another felony and is using this as an out, possibly, then I would have no hesitation.

Mr. HUNGATE. It is my recollection that one section of one of these bills provides if he has a prior offense charge pending, he is ineligible for consideration.

Mr. KUH. I believe that is the law in New York.

Mr. HUNGATE. In other words, whether he has been convicted or not, if he has a prior felony charge pending, he is not eligible for treatment under H.R. 9167.

Mr. KUH. In New York, as I pointed out, there is no way the addict is going to elect this civil commitment and get out on bail. He has to act quickly. We do not want a situation where the addict who has a burglary, or what have you, pending and he faces some serious crime and has not claimed to be addicted, and so forth, then suddenly scratches his head and says, "Gee, if I get rearrested for drugs I can go into the hands of the doctors and put off this burglary case until the witnesses to that may have disappeared." In other words, he has a

case which he has stalled for 6 months so far, and now he is told, "You be in court tomorrow morning ready for trial, or else." He says, "I will get myself civil-committed."

So we provide where he has a pending felony, I believe that is the provision of the New York law, he is ineligible.

Mr. HUNGATE. You support that provision?

Mr. KUH. Yes; I think that makes sense. In other words, in another situation he could not or did not say, "I am a sick man." He had been either barred by the statute from making that election or he did not make it, and then it seems to me you should see that through.

Mr. HUNGATE. Do I understand your position to be that if he had previously been convicted of a felony and comes in, he would be entitled to elect; but if he had previously been charged but not convicted, he would not have the right to elect?

Mr. KUH. I agree it sounds highly inconsistent. Yet I think it has a practical impact. Ordinarily if a defendant has two charges pending, at least I think in terms of New York now, if the greater one is disposed of, it covers both and the lesser will be dismissed. In other words, where the defendant has been stalling a burglary trial for 6 months and then is picked up with possession of drugs, if he pleads guilty to burglary or is convicted of burglary, the chances are he will be sentenced under burglary which will cover all charges against him, and the drug charge will be dismissed.

So, I think there is some logic to saying we are not going to let defendants escape from the delayed administration of justice by running to a hospital. On the other hand, if he has had the other charge completely disposed of and sentenced on everything else, then it seems to me if he is now arrested for a narcotics crime it may be wrong to hold that against him.

Mr. SHATTUCK. Following up this same idea.

A man is in Federal custody. He might be eligible for civil commitment under one of these bills.

Mr. KUH. Yes.

Mr. SHATTUCK. But there is also a hold order out against him by reason of a State crime, which also is a felony. This would reach an impass. The Federal Government could not hold him for civil commitment, and then it would normally go ahead and elect to prosecute and the State might decide not to proceed, and there we are.

I don't know whether this is a serious objection. Perhaps it is something we cannot surmount.

Mr. KUH. I think this is something one would have to trust and leave up to the judgment of the prosecutors working together. If you have a nonnarcotic crime, you have the prosecutors' veto power. You might have the State prosecutor, knowing the Surgeon General's program is more businesslike than our State program, say "In the interest of judgment we will deny him civil commitment and keep the State criminal charge pending. You civilly commit him to the hospital under the auspices of the Surgeon General."

No matter what is drafted one always can find other things that will have all sorts of impact. This happens.

If you have two jurisdictions fighting over a man something can be worked out.

Mr. SHATTUCK. We understand that. This is a practical problem. I can sympathize with the State authorities here that they would not

want to dismiss their charge. On the other hand the charge has not been determined.

Mr. KUH. The State authorities—thinking in terms of New York—if the defendant is eligible for Metcalf-Volker in New York and one of your bills federally, the State authorities could, if the State crime is a narcotic crime, say: "In the interest of justice"—namely, a more important Federal case is pending—"I will deny Metcalf-Volker treatment."

If it is not narcotic crime the prosecutor without giving reasons can say they will veto it, and then criminal charges remain pending in New York. We could simply delay processing the criminal charges until the Federal courts followed their course.

We might find ourselves in New York in a situation where the defendant could move to dismiss our charges for failure to have afforded a speedy trial.

Mr. HUNGATE. I have a question on section 3813, of H.R. 9051, where the Surgeon General is asked to certify that the person has been effectively removed from habitual use of drugs.

Is it your view this is a sort of statement the doctor would not care to make?

Mr. KUH. When we drafted what became the Metcalf-Volker law, we had people from the State hygiene department and others there. We wanted something in there to certify that the defendant is cured. I think "effectively removed" states almost the same thing.

The doctors pointed out that you never know. You get into a sidelight here, but the State parole division deals with addicts and they have a rate of about 30-plus percent who have remained off drugs for a long period of time. Yet they continue to follow up. Even though they have been off drugs a year or two they may go back. "Effectively removed" to some doctors would mean cured. A doctor does not like to say anybody is cured.

Mr. HUNGATE. The administration bill, H.R. 9167, states "successfully completed the treatment program." Do you think that is more desirable?

Mr. KUH. Yes. This, in effect, lets the doctors use better judgement. The whole point of the bills is saying: "We want to put the addict in the hands of the doctors."

Mr. KUH. Yes. This, in effect, lets the doctors use better judgment. The whole point of the bills is saying: "We want to put the addict in the hands of the doctors."

If you put them in the hands of the doctors, you as a prosecutor, policeman, lawmaker should not tell the doctors what their standards are or try to tell them.

Telling the doctors: "You set up the treatment program, and if he complies with this, that is all we ask."

Mr. HUNGATE. As I understand it, New York is the No. 1 State in the narcotics problem and there are some 30,000 plus there. That is $15 million a year for 3 years as proposed in the Kennedy-Javits measure. Missouri has 400, according to the figures. I would like to hear your discussion on that as to why—well, the administration bill does not provide funds in that case and the other bill does.

I would be interested in any justification you might submit or non-justification.

Mr. KUH. I think by way of justification, our narcotic problem is a heroin problem. There are some morphine and some cocaine but basically it is heroin.

Under the law no heroin is in this country lawfully. In fact, heroin is an opium derivative. Opium is not grown domestically so any heroin sold in New York City, New York County, and Harlem came in from outside.

We are now talking about philosophical justification for heavy Federal expenditures in the area.

I could be rude, and it would be rude and dishonest to say, we would have no city problem if the Federal people did their job and kept it out. That is rude because it cannot be done. You can double the Narcotics Bureau and triple the customs agency and heroin can be so easily smuggled in that it will come in, anyway, no matter how you blew up those budgets.

Yet realistically if you tripled customs agents and so on you would keep out some more. How much more percentagewise I cannot say, but you would keep out some more than you are now.

Anything moving in international commerce starts with some degree of Federal responsibility, so I think quite legitimately New York can say we would have no problem if the United States of America kept out heroin. That is one rationalization for spending sizable sums.

Another is, as you know better than I, increasingly the Federal Government sees its responsibility in many, many areas—health, where we have medicare; problem of minorities, principally affected in big cities by heroin addiction. We have the civil rights program there.

In health problems we have the existence of the Surgeon General's Office as Federal recognition in the area of health.

I think we have to use the tools. We cannot expect Federal cops to come in. In 1963 or 1964 there was something like 13,000 narcotics arrests by the New York City Police Department. We cannot expect the Federal Narcotics Bureau which may have 20, 30, 50 agents in New York City, to suddenly send in 3,000 agents. We are ready to do the policing job, but I think we legitimately can expect the Federal Government to help us as a health problem, help us as a minority problem, help us in terms we have no problem if the Federal Government kept out the drugs.

As I say, the very existence of things like Lexington and Fort Worth are indicia that the Federal Government for many years has recognized responsibility in the area, so I strongly am for the $15 million a year.

Incidentally, $15 million a year sounds like a lot to me. You are in Congress and you hear these figures more frequently than I do.

Mr. HUNGATE. It sounds like a lot to a Congressman from Missouri.

Mr. KUH. In terms of dealing with the narcotic problem it is nothing. I criticized mental hygiene. They are up to $6 million. It is very expensive to do this.

Mr. HUNGATE. Thank you very much.

Mr. ASHMORE. Mr. Kuh, we appreciate your coming here today and giving us the benefit of your knowledge, experience, and work in this field.

You have answered many questions to which we have been looking forward to asking.

I wish we had more time. We have to answer a quorum call. It is now 12:45 and we will have to suspend the hearing now until a later date.

We shall resume at 2:30.

Mr. KUH. Mr. Chairman, since you might not be here this afternoon, I have appreciated the interest you have shown and the fact you are in this whole area. I think anyone interested in narcotics is indebted to you for it.

Mr. ASHMORE. This is a most important field and we want to do everything we can to get some legislation that will be beneficial to the country.

If you will come back at 2:30 we shall continue with the hearing.

AFTER RECESS

Mr. HUNGATE (presiding). The committee will resume its hearing.

I believe the minority counsel has some questions, is that correct?

Mr. HOFFMAN. Thank you, Mr. Chairman.

I have one or two questions which Mr. King asked me to ask, and one or two that Mr. McClory asked me to ask. Since we have one man, one vote, I might continue a little longer than otherwise.

First, you are unquestionably aware of the figures as to preaddiction criminality which have arisen from various sources, I take it. The New York office ran a study on some addicts, and in New Jersey, and there have been a couple of California studies, showing anywhere from 77 to 92 percent.

Would you comment on those figures?

Mr. KUH. I have seen various sets of figures—I am not sure how reliable any of them are—indicating that x percent of defendants who are ultimately arrested for narcotic crimes have prior arrests for nonnarcotic crimes or x percent of the defendants arrested for nonnarcotic crimes state that they were addicted although not previously narcotic-arrested, so to speak.

The only comment I can make is one that it would be more in line for a medical person to make, that obviously a narcotic conviction is to some extent likely to be the product of an antisocial personality, a psychopathic personality, if the same personality picture is one which produces crime other than narcotics.

The question of which came first I do not think really matters too much. One must realize that the narcotic addict is likely to be a person with criminal tendencies, anyway.

Query: The last part of your question, the impact of the bills before you and the New York law in this situation. I think all it does is underscore the folly, if I may use that word, of the so-called English system, the clinical system, which in effect is premised on various false assumptions, one of which is if you remove the need for the drug, you remove the need to raise money for drugs and therefore you remove the need for men to steal to raise money for drugs.

I think that is a very neat and appealing system, but I think it is false.

None of these things I say are 100 percent true, but are likely to be true. The addict personality is one who prefers his antisocial way of living to one in which he stands in line for things and punches

a time clock at 8:30, and so forth. The idea if you give somebody drugs they will suddenly turn out to be Little Boy Blue is a fraud. It just does not happen.

In terms of commitment to a hospital or medical facilities or medical care in lieu of processing, what this does is get the addict in the hands of the medical men, the doctors, social workers, and followup people at the earliest possible moment so they can deal with this whole personality, part of which is the addiction proneness, and follow through on his addiction proneness and use of drugs, part of which is the broader picture of his antisocietal personality, psychopathic, sociopathic personality, the personality that dictates that he rebel at obeying restrictions which society puts on him.

As I hear myself talk, I think maybe I should have gone to medical school instead of law school. This is mostly what I get over a period of years from attending conferences and doing a lot of reading and talking to a lot of people. You see addicts yourself and you wonder what makes them tick.

I think the sooner we can get the addict in the hands of some treatment authorities who, hopefully, have a real treatment program, dealing not only with his addiction but the whole personality, they may help.

I referred before to Thurgood Marshall's quote from this morning's New York Times, which I am sure was in the Washington papers as well. You get a way of taking the addict out of our traditional penal framework, taking the criminal addict, the addict who has criminal tendencies apart from this addiction, out of the penal framework, and you get him into a productive framework that protects society from his various depredations as well as effecting a cure.

Mr. HOFFMAN. As I understand, the whole problem of rehabilitation is the criminal and/or antisocial character. You view these as going out to the addict as no different from the ordinary criminal, but because of his addiction he is approachable from this other angle. Is that a fair statement?

Mr. KUH. Yes; I think it is. I think ultimately our criminal methods or at least our court methods will be changed. I do not want to get into something which is not now before you, the problems of using confession, the problems of search and seizure, all of which are increasingly making the criminal law to some extent unworkable. I think at the same time you recognize, even when the criminal law works, there are some limitations in terms of how much good it does in terms of rehabilitation. It seems to me the law does not accomplish what it should. We are gradually pushing to an area where we are trying to reconstruct personality. This is a major problem.

I gather from scientists that their success with the psychopath is not very great. Yet this is a way of taking a group of persons, many of whom have similar symptoms—they use drugs and they commit other crimes—and isolate them and see what we can do to help them.

Mr. HOFFMAN. Referring to your remarks before the Senate Permanent Subcommittee on Government Operations, I wonder if you would comment on the extent to which the addict really wants to go to the hospital and be cured. You mentioned your experience with the marihuana users. There has been testimony about the addict who

is completely cured. He said, "I am going straight, but you really don't know what you are missing, Doc." Have you any comments on that to indicate how deep seated this problem is?

Mr. KUH. I do not mean this critically, but again this is something that might be more expertly answered by the psychiatrist, psychologist, and so forth. From my own view, the same people rotate through the courts. One talks with people and from contacts in the hospital framework and aftercare framework you get the picture there are addicts who are finally and ultimately fed up with their addiction and who want the cure, and there are addicts who find their habit getting so expensive that they want at least temporary respite to cut down on the expense of the habit, although ultimately they start all over again. You find the streetwise addict that I mentioned, who may convince the judge to send him to Lexington, who may sneak out the back door or walk out 5 days later. This beats getting 60 days in jail. So, you find addicts who embrace cure, so called, for various reasons.

The sad thing is that even the addict who is not doing it because he is streetwise, who is not doing it because he wants to cut the expense of his habit, but the addict who really wants to shed his addiction, will sometimes, after a few days or a week or 2 weeks when the initial impact of the strong resolution is over, stride back and is looking for a shot again. It is the old problem of New Year's resolutions. On New Year's morning we all take them seriously, but a week or two later we may have gotten away from them.

I criticized this morning the State mental hygiene department. One of its representatives made a statement in New York in April of this year, pointing out that the State mental hygiene department had a methadone maintenance program. That is methodone hydrochloride, a synthetic which, if given to a person addicted to heroin, will prevent withdrawal symptoms, and as long as the person gets methadone he does not need heroin. Methadone does not give the kicks that heroin does. But if the addict is not really crazy for kicks, methadone will at least make him more amenable to psychiatric work.

The State mental hygiene department started a methadone program for its addicts some few years ago. When they started the program they anticipated they would be flooded with all the addicts, saying, "Yes, I want methadone and I want to get off heroin." Their experience was quite different. They put up notices in the hospitals. They did everything they could to convince addicts to take methadone. They were unsuccessful.

Let me read part of his statement. He said:

> Those who declined our offer did so because of their unwillingness to commit themselves to a structured interaction where the goal would be community adjustment rather than self-indulgence.

Then he gives the figures on what turned out to be a tiny program of 23 persons. He said 9 of the 23 left the program in less than 2 weeks. Of the remaining 14, 9 did poorly by the time they reacted in the community. The methadone program was an outpatient program, started in the hospital and then released to the outpatient program. Only 5 of that handful, 5 of the 23, made a fairly good adjustment.

So the experience has been that even the addict who really thinks he wants off drugs is likely to backslide.

Mr. HUNGATE. May I interject a moment here. We had one witness who testified on methadone and was rather critical of it, with the view that you replace the narcotic addict with the methadone addict. What would your views be on that?

Mr. KUH. Mr. Chairman, I stress this is something on which a doctor's views might be more worth while than mine. New York City now has a major methadone program. Dr. Vincent Dole with Rockefeller Foundation funds started with a handful of people, I think eight addicts or six or so of them. The figures seem to be meaningless. He met some success. Now he has more funds and that program is to be expanded.

I gather from the doctors who have worked with addicts on methadone that it does substitute one addiction for another. This is all short range because there has not been long enough experience with methadone. The advantage, however, is the addiction is in a way less pernicious. It is a less euphorious addiction. It is an addiction that leaves enough of the human drive, motivation, and so forth, that the person on methadone can work for a living, has drives to work for a living. He does not want just to lie back in euphoria.

I am really giving you the rankest kind of hearsay. Never, to my knowledge, have I seen or spoken to anyone on methadone so that I could give it to you firsthand. On the other hand, if we do find that methadone with an appreciable number of addicts makes them more adaptable to outpatient care and to working productively in the community and to working with psychiatrists, psychologists, social workers for their own ultimate salvation, so they ultimately will shed all addiction, then methadone is a good way station.

Mr. HUNGATE. Getting back to the legal language of the bill, the time for making examination, one of these bills, H.R. 9051, proposes an examination within 10 days after the election to be treated. The other one provides 30 days, to be extended an additional 30 days.

I wonder if you would give us your views on the merits of the two approaches.

Mr. KUH. My criticism of both proposals this morning—I hope this is not solely pride of authorship—was that it seems to me the sooner the election is made, the better off everyone is. The better off the community is in the sense you do not have somebody who by hypothesis is on the community. The better off law enforcement is in that you have a strong indication that, in fact, the person is addicted because if you arrest him one day and examine him in effect the same day, you are watching him and know what his symptoms are. As soon as you wait 10 days or 30 days or an additional 30 days, you risk, it seems to me, a situation where the defendant presents whatever picture he wants to present. If he wants you to think he is addicted, he has been on bail taking drugs during this period.

Mr. HUNGATE. Let me take it back one step. We first talk about the time within which he may make an election. One statute would permit 10 days within which to make the election, and the other one 5. As I understand, you would favor the shorter period in which he would make the election.

Mr. KUH. Mr. Chairman, I favor the shorter period or, whatever the period is, that he would have to remain unbailed until he made his election, without bail, in a facility where, in the interim, he should be observed by a doctor so they can determine his condition.

Mr. HUNGATE. If he is held without bail for the period until he makes his election one way or the other, then you have no preference particularly between the 5 or 10 days?

Mr. KUH. Not really. I think the 5 days ordinarily is enough. Yet, if a person has had a very, very substantial habit, the first 3 or 4 days he is so sick that he really may have had only 24 or 30 hours to make an intelligent choice. I have no objection to the extension of 5 days, provided he remains in custody during that period.

Mr. HUNGATE. Once the election is made, he is to be examined. One of the bills would have him examined within 10 days after the election, and the other 30 days. Which of those periods? Do you think the shorter period would be preferable?

Mr. KUH. Here again, I think the shorter period. This is one area where I am not fond of either of these bills. I think it is artificial to expect the examination itself to show anything, even under the shorter period. If he has 5 days to make the election and the examination is to be within the next 10 days, you could have 15 days gone by after the time of arrest, and to expect at the end of 15 days to be able to tell whether the defendant is or is not an addict is subject to too many masking factors.

Mr. HUNGATE. You mean even if he is held without bail?

Mr. KUH. If he is held without bail, then he obviously is kicked by the end of 15 days, and you cannot tell anything other than what you can tell by the observations of the jailers during the first few days of the 15 days, whether he was sick or was not sick, what he was going through. In other words, at the end of 15 days the addict who has been physically removed, who has been clean for 15 days, is not going to be sweating, is not going to be sick at his stomach, he will not have physical symptoms. He will still have needle marks, and conceivably with some expertise you could tell if they are relatively fresh or old needle marks. But in terms of judging his then habit, his habit as of 15 days ago, you are dependent to a large extent upon what he tells you about himself.

Mr. HUNGATE. Assume he is being held without bail, what would your recommendation be as to the time when he would be required to make an election and the time when he is to be examined?

Mr. KUH. I would put the recommendation in just the other order, Mr. Chairman. Any defendant who is arrested, if he shows any signs of addiction, goes through withdrawal, sweating, fever, et cetera. If he is arrested for a narcotic crime, then clearly the detention facility personnel should be watching him and seeing him. If he needs medication of some kind, to see what then the medical personnel attached to the detention facilities can ascertain by their observation and by their own medical training. This should start immediately upon his being sent to a detention facility so you have observation to know what he has been going through.

This is a much more reliable basis. I am not sure I am being clear, Mr. Chairman. All I am saying here is that I am removed from the street, the police lock me up tonight, and by tomorrow I am lodged in local detention facilities. I think in New York terms, but I think this would be true in any community. The defendant lodged in the detention facilities is then, as part of the routine program, seen by a doctor to see if he is carrying any venereal disease, any communicable

diseases. Is he black and blue in terms of whether he has been beaten. In New York there is an examining physician who examines someone. It is not a detailed examination. Every person in the detention facility has some medical examination. For the person who at that point any withdrawal symptoms or the person who is arrested for a narcotic crime, this examination should have in mind watching him for withdrawal symptoms. It may be telling the correctional guards around him to keep an eye on him, and a record should then be made.

If the defendant is addicted, you will see withdrawal when he is first withdrawn, the first 24 or 48 or 72 hours that he is off the drug. The steepness of his habit, the intensity of his habit, will determine what withdrawal you see. You are not dependent on what he says to you and you are not risking the fact that he is out on bail taking drugs or not taking drugs. You see it then.

It seems to me that the examination in effect should start the moment he is admitted, medical or medical supplemented by what his warden or custodian sees. Then in terms of his election, he should not be pressed for an election until it is obvious that he is no longer under the physical strain of withdrawal, such as that a decision might be unintelligent, motivated by the pain that he was going through. As soon as he has passed that physical withdrawal, he should have a limited time to make an election. A period of 5 or 8 days from the time of initial arrest I think is adequate.

We should not run into a situation where you are holding someone against his will. There should be a proviso for one who says, "I don't want civil commitment. I want out. I want to set bail. I will take whatever risk there is to be run of conviction." The judge should tell him, "Mister, there is this election program. If you want it you cannot be bailed." If he says, "I prefer to be bailed," fine, let him be bailed. He may get further drugs outside.

Mr. HUNGATE. I yield back to Mr. Hoffmann.

Mr. HOFFMANN. You mentioned earlier in your testimony that there is a provision in the New York law that if, after making an election to try out for the program, there is a finding made the man is not an addict, he can appeal this. In other words, he can have a hearing on it.

I noticed also in the Metcalf-Volker Act there are other reasons set out. This is in section 212, paragraph 6(d) of the act, pertaining to the nonnarcotic crime, which I will take as an example. Suppose it is found he is an addict. The judge determines it is not in the interest of justice to commit the defendant or the prosecutor does not think that. Does he have a hearing after those two determinations and, if not, how do we get around it?

Mr. KUH. He has no hearing. How do we get around it? I guess in two ways. I guess you are getting into the constitutional area. One, if the judge says it is not in the interest of justice, the judge does not have to give any reason for so saying. However it were done, the judge might be pressed for the reason why he found it not in the interest of justice. If the facilities are inadequate, I guess the way of getting around it is simply that democratic society is not perfect. We do not automatically have ideal jails.

In New York State there are some prisons that are happier prisons than others, some where State prisoners would prefer to go than to

others. Yet, I know of no one as yet who has brought any writ and said, "Why was I sent to Ossining where I wasn't allowed to have a television set in the day room, instead of Sing Sing where I was?" I am using these as examples.

Mr. HOFFMANN. The trouble is that he has not been found guilty at that point. There never has been any suggestion that due process applies to the judge's discretion in sentencing. If there is any opportunity at all for an extra hearing or extra procedural step, it will be taken in Federal procedure. The thing I wanted to find out is if it has proved a problem under New York law. In other words, a person comes in and says, "I want to be civilly committed," and he is not qualified, and he says, "I want to know why." He might even try to upset his conviction because he was not accorded due process in the choice between these two means of approach to his case.

Mr. KUH. The point is certainly a valid one. I know of no case in New York which it has been raised, as I indicated to you. I know myself of no case in which the hearing provided by sections (4) of 211 and 212 was even asked. There may be some. I do not know how to answer that.

It seems to me in the Federal system the courts would have to take cognizance of the fact that it takes personnel and aftercare workers to do anything with the addicts. If there is a limited number of beds, someone will have to make a selection. If the court does not accept the addict on the basis that the interest of justice would not be served, and the court is not ready to rationalize if called upon, then the Surgeon General would have to. The Surgeon General, it seems to me apparent, must consider it on a dual basis. First, how many beds have we at this particular time and then, second, not making a legal determination by proof beyond a reasonable doubt, not making it by preponderance on the basis of the evidence, but merely on the diagnosis of the doctor, we think this guy stands a better chance of success than that guy. This is not the sort of thing that we are used to in criminal courts or in civil courts. Yet, unless overnight you are going to set up beds enough and workers enough to deal with every possible emergency, some people are going to be rejected in a medical judgment.

The standard of constitutionality, it seems to me, in any area is whether it is reasonable. That may oversimplify it a lot. One judge finds something reasonable because he likes it, and another judge finds it unreasonable because he does not like it.

Mr. HOFFMANN. It depends on the judge. It may vary between the district court and the appellate court.

Mr. KUH. It does seem to me at least the argument can be made whether it is reasonable to give the Surgeon General, if you will, veto power because it is unreasonable to expect the Surgeon General overnight suddenly to have a thousand beds available, or even 5 years from now to expect the Surgeon General to continue his bed capacity and staff for any potential volume.

The Surgeon General has to know approximately how many people he is going to have, and then have roughly ultimately beds for those people, but he cannot be expected to have beds and trained workers sitting idle 8 months of the year because 4 months of the year there may be a demand for them. It seems to me the structure must recognize this, nd thus to give the Surgeon General veto and selective power because

he does not have personnel and beds available, I think would be inherently reasonable. I can see there are judges who might disagree.

Mr. HOFFMANN. A further question. Is there any requirement in the New York law in the case of an addict who has committed a nonnarcotic crime that there has to be some relationship between the addiction and the crime? In other words, with the shoplifter there is a pretty obvious connection. A fellow who steals a car can sell the car. In Dwyer Act convictions, you have no relation. He happens to be an addict and he happens to have stolen a car. Is there any requirement to prove a connection?

Mr. KUH. There is not. Again we are getting into the medical lingo. The doctors say if one is dealing with a personality, you cannot chop the personality into little pieces. Nobody knows that better than judges, in at least the District of Columbia in the *Durham* case. Here you have the whole picture. In the *Durham* case you get into the problem if a person is mentally diseased and he commits a crime which is by definition a deviation from the normal, ergo, there is by definition a connection between the mental disease and the offense.

I think with the addict it is the same thing. I do not know how you prove it, other than the analogy I gave before. If he breaks Tiffany's window and steals jewelry of $100,000 value because he has a $10-a-day habit, it would seem the crime is at best remotely connected with his need.

May I point out that under subdivision (d) of section 212, we do recognize the point made before, recognize that beds will not exist in inexhaustible supply. We do create a priority for the use of beds which may help sustain the argument that what we do is reasonable and not arbitrary. We state the court shall not civilly commit a defendant, even though he has been determined to be a narcotic addict—I am talking of the nonnarcotic crime addict—if it appears that facilities certified by the commissioner of mental hygiene for hospital care and treatment of narcotic addicts or for their aftercare supervision are inadequate at the time commitment is sought. As long as the inadequacy of such facilities persists, the court in making the determination of whom to commit civilly must deny such method to those addicts who have been arrested on felony charges and may deny such commitment within his discretion.

In other words, we create to some extent a logical progression concerning who gets the beds.

Mr. HOFFMANN. While we are on this general subject, you mentioned before the Senate subcommittee the possibility of interstate compacts between States to provide for the exchange of narcotic prisoners or narcotic internees, or whatever you call them, on a pay basis. It might be possible under overall Federal sponsorship if Federal funds came into the area. I do not know whether you touched on that this morning. Do you want to comment on that as a possibility?

Mr. KUH. I suppose New York has the major addiction problem. Rhode Island is not far away. I do not know much about Rhode Island, but I assume it is a relatively small problem but will become larger.

Mr. HOFFMANN. Take Connecticut.

Mr. KUH. Connecticut may today be having a problem, but still, in terms of New York City, infinitely small. If Federal funds are

available and there is a matching basis which also pays the expenses of the hospitalization and aftercare on some sort of matching formula, it may not pay Connecticut or Rhode Island to build an institution or even build an entire wing of a hospital. It may not pay Rhode Island or Connecticut or they may be unable to recruit personnel for their operation because their operation would be so small. A doctor with many years of training or a social worker with some years of training do not want to specialize in an operation that is so small that there is no future for them. They have just a handful of people. They are just a specialist with no place to go.

It may be that it would be more efficient and effective and more economical for the State of Rhode Island and the State of Connecticut to say, "We could get $3 from Uncle Sam for every $1 we put in, but we cannot get trained people, and we cannot do the construction here. We will pitch in our dollar and will pitch in the $3 we get from Uncle Sam to New York. Will you handle our 20 commitments?"

These are things that, if you had some sort of overall coordinator for the narcotic program similar to what I suggested in New York State they should have had, you would have someone who could work out these compacts between States.

Mr. HOFFMANN. May I ask you finally to comment on the need for a Federal commitment bill. The Federal jurisdiction in narcotics is usually coincident with the local jurisdiction. It oversimplifies the problem somewhat, but the Federal jurisdiction is interested in big trafficking and major criminals, whereas local jurisdictions would be interested in individual offenders. There has been testimony before the subcommittee as to how many Federal prisoners would be reached under this civil commitment. I think the figure is anywhere from 700 to 900 a year.

Where do you draw the line? From your experience, where is the line drawn between the State prosecution and the Federal prosecution in the narcotics area, and aside from the consideration at the end of your statement as to the effect it would have upon its enactment into Federal law, do you think it practical to consider that the Federal statute could be pretty limited because the case of the small criminal who might be a major addict problem rightfully would belong to the State, and if he did run afoul of the Federal law and was picked up in a dragnet operation, or even as a pusher on the street came to the attention of the Federal authorities, that he would be turned over to the State for prosecution, and then these processes available to him under the State jurisdiction?

Mr. KUH. You raise several questions, Mr. Hoffmann. I think first in terms of the breakdown I think it is really a problem of recognizing there are limitations in terms of personnel. The Federal Narcotics Bureau does not handle the little guy, that pusher. They just cannot waste time on that because of numbers of people, so that States do most of the smaller efforts. The city police take care of many of them.

I know the point is that the city will not only take the small guy but to get a major case the city also will handle that. The city will handle anything it can get its hands on, city or State.

The Federal agents because of limitations on their personnel do not move in on the little guy.

Does it pay to have a Federal program, other than setting an example? I am talking about an area I don't know firsthand, but I

know part of the Federal jurisdiction is this District of Columbia, where I gather addiction is not slight. I gather there is a significant number of narcotics right here in the District. Here you have no State-Federal problem. Here local crime becomes a Federal crime. Hence the program would be of considerable help right here in the District.

I see the Attorney General's statement on July 14 in which he pointed out that 43 percent of the people in Federal prisons were there for nonnarcotic crimes but were addicted, so apparently there is some need felt by the Attorney General in terms of the Federal picture for dealing with these persons in a public health framework.

I don't know if I have answered the question but you are asking me about Federal jurisdiction about which I don't know firsthand. Here I refer to the Attorney General's statement and to my secondhand knowledge of the problem of narcotic addiction in the District.

Mr. HOFFMANN. The idea was that if the District of Columbia had a law passed it would cover the rest of the country as well. I think the figures you are quoting from the Attorney General are slightly turned around. I am not sure the figure is 43 percent of all addicts in Federal prisons who are there for nonnarcotic crimes. I am not sure about that.

Just in New York, then, would you say that if New York had an effective properly funded program with adequate facilities that this procedure I outlined of the Federal people turning over those prosecutions which they felt were proper for a civil commitment, wouldn't that handle the problem?

Mr. KUH. It would seem to me that you are getting really into the physical facility aspect, the personnel. It seems something could be worked out in the statute to provide that the Federal Government could work out some compact with the local States, such as we discussed with Rhode Island, Connecticut, and New York.

It seems to me you still would need a basic Federal program. In other words, what about this election? Does the U.S. attorney, if I am arrested by a Federal narcotics agent for possessing or selling narcotics, what happens? How does the U.S. Government decide? How do they do it? Do they do it after I am convicted? Do they do it at the outset? Under what authority do they do it?

It seems to me you still need basically something like Congressman Celler suggests in his bill, and further that the aftercare made by compact be handled through local facilities.

Mr. HOFFMANN. My question had to do in terms of dealing between prosecutors and even between the two narcotics squads. In the District of Columbia, for instance, some Federal people have come across an operation which does not look large enough to handle and they turn it over to the local police. I don't know it can be formalized, and I suppose based on your remarks it could not be.

Mr. KUH. It seems to me to some extent in any law we have to realize we are dealing with people and how they administer it. There tends at times to be rivalries. Even assuming a small number of narcotic addicts, I don't know it would be wise for Congress to say, "Let us ignore it" and then hope the local police chief will work out something with the Federal narcotics agents in terms of handling it.

Some want to be lenient and some want to be tough. Federal pol-

icy would be wise to say, "We want to protect immunity and we want to rehabilitate this man and treat him humanely." You have two bills which give a structure for doing that.

Mr. HOFFMANN. One or two judgments have to be made—one has to do with the impact of these laws on the present law structure with regard to narcotics. Some witnesses have suggested it would be a general weakening of the law, and then there is the present structure of laws which are quite restrictive.

Then there are competing interests, the extent to which this additional procedure will encumber with still another procedural step. I am not trying to lead you but to get your idea.

Mr. KUH. There are various ways of looking at it. Certainly if we scrap both the Celler and administration bills completely, eliminate the mandatory minimums which now exist, those same people who criticize these will in my judgment criticize that as a major weakening. Experience shows you deal with many judges and they each have their own philosophy. Ultimately cases that get before the most lenient judges are the maximum number of cases. The man with the most lenient philosophy handles the greatest volume.

I think there is a need for mandatory minimums.

Increasingly the communities have been moved by the idea that addiction is not solely a criminal matter, that it is a public health matter, so I think an approach like either of these bills is a good compromise.

It tells the addict, "If you are treated in a penal framework we will give you hell. We want to protect the community from the danger you represent. We will keep you in jail and keep you there a long time."

On the other hand we say, "If you are serious about being treated we will give you every opportunity."

Of course, the one big question mark, and I can see where people are worried about these bills, is how will the Surgeon General administer this program. The Surgeon General has vast experience in dealing with contagion and narcotics and I think his viewpoint is fairly realistic. There is no way of knowing until we get started.

If we found the Surgeon General turning people loose 60 or 90 days afterward with no meaningful aftercare, either the Surgeon General can be restricted or it can be taken from the Surgeon General, or the whole plan can be abolished.

Mr. HUNGATE. I believe I should now have Mr. Shattuck propound some inquiries.

Mr. SHATTUCK. I have a series of questions. We are talking about the existence of facilities. The administration bill provides for contracting authority on the part of the Surgeon General as to the preconviction aspect of the bill as opposed to the postconviction portion of the bill which places similar authority in the Attorney General. He shall have the right to contract for use of facilities. We are going back full circle in the utilization of State and local facilities which is a problem.

In your testimony you have said this does not exist. Do you have any views as to how this might be handled on this level?

Mr. KUH. I think there is one way of implementing it, and that is as was done in the area of education and everything else. The Federal Government gives funds and does not give them without strings.

It says "You may get x dollars if you put up y dollars; B, if you keep up certain standards."

One of my criticisms of my State hygiene department is that they seem to be reporting to no one and seem to be doing very little.

If State mental hygiene learns they will get $5 million a year, or $2 million a year, from the Federal Government they will have to not only prepare a plan but show, in fact, some followthrough on a plan that is satisfactory to the Federal Government. This gives it some initiative. If it does not get Federal funds because it does not do it then the local electorate which is concerned with the narcotics problem can do something about it.

They can say if you had a sound program you would have gotten Federal funds.

Mr. SHATTUCK. You refer to the grant-in-aid portion of the program. As to the administration proposal it does not mention this but gives promise of a contract for that type of facility. Is it reasonable to suppose that the State or the city or a private organization could create facilities under a proposed contractor promise of a contract to provide this kind of aftercare facility we have been talking about?

Mr. KUH. This is a real problem. You talk to New York Mental Hygiene about their slow procedure, and they refer to the time it takes to train workers.

I guess if the proposition is made attractive enough, if one cannot get a Government agency to do it some private agency would do it.

I really can't answer that.

Mr. SHATTUCK. It is an unfair question in a sense. I wondered from your background in the field whether you had any feelings on it.

Mr. KUH. My feelings were that if I were contracting with someone I wouldn't contract with the New York State Mental Hygiene Department at this point, but beyond that I look at something like the East Harlem Parish. They have been one of the ground breakers in New York State in the work they have done. Initially they had a grant from Doris Duke, and they now get some city funds and possibly some State funds. They are an aggressive group and trying to do a job.

I venture to say the Federal Government might ask whether they are ready to expand and have a larger aftercare program. I would venture to say they would be pleased to do it. They are not in this for profit but they are a community do-gooder group which really knows the job it has to do.

It seems the Federal Government is in a position to shop around for facilities.

If you had a unit as large as 800, for example, it seems better for the Federal Government to create its own unit. If you had 30, 40, 50 addicts I venture to say with proper Federal inducement you could find some good nonprofit group to handle it.

Mr. SHATTUCK. Thank you.

Mr. HUNGATE. Once again I want to thank you very kindly for your time and coming back again this afternoon and patiently submitting to the slinging arrows of the committee.

Mr. SHATTUCK. Mr. Chairman, at this point in the record I would like to insert various statements.

Mr. HUNGATE. At this point in the record we shall insert a statement of District Attorney Frank D. O'Connor, Queens County, N.Y., on this measure.

(The statement referred to follows:)

STATEMENT OF DISTRICT ATTORNEY FRANK D. O'CONNOR, QUEENS COUNTY, N.Y.

I am honored today by your invitation to testify before your committee.

Unfortunately, I cannot avail myself of its thoughtfulness in person. I would, however, not want to forgo the opportunity entirely of commenting on the significant legislation under consideration by your committee in the field of narcotics addiction.

I will not repeat statistics and truisms about the prevalence of narcotics and the danger addiction holds for its victims or the society they variously plague by criminal acts and moral weakness.

This is all rather common, discouraging knowledge.

Nor do I wish to belabor the fact that this legislation is what is commonly known as a milestone or a breakthrough in our advancing attack on a persistent and tenacious problem.

It is all of that even as it is but a first step of many of the same kind and other kinds that must be taken in what surely will be a long battle against an ancient malady.

The legislation under consideration recognizes certain realities the Federal Government has never quite acknowledged so publicly or completely before.

(1) That addiction is a sickness that should be treated carefully but also more widely and deeply than ever before.

(2) That addiction breeds crime that must be "punished" if the perpetrator will not lend himself willingly to an attempted cure.

(3) That what has been done so far leaves much unchartered territory both in official courage and scientific knowledge; that one cannot come without the other; but that each taking the lead on different occasions must certainly follow on the other in various ways and degrees, if we are to do something more than ride the sad carousel of addiction, crime, arrest, jail, empty sentence serving, and out again to ride the real tiger.

This legislation recognizes, too, several facts that are well established if not widely acknowledged before by Federal authorities:

That while narcotics traffic is a Federal problem initially, addiction is a State, indeed, a local problem ultimately: that the various States need financial help to build facilities to maintain old programs and to initiate new ones; that in order to accomplish these and other objectives, the Federal Government must appoint an advisory committee to evaluate and help coordinate present programs and to fashion future programs.

Here, however, I must take a departure not in philosophic but monetary principle with this legislation.

Fifteen million is too little to appropriate for a 3-year period if we are to build a Federal-State-city facility in New York alone as we must eventually. New York has 40 percent of the known addicts in the country. It currently maintains some 500 to 600 beds in the city at 3 hospitals. Narcotic felony arrests totaled 10,154 in 1964 to 6,221 in 1963. Narcotic related misdemeanor arrests totaled 10,154 to 6,221 in 1963. We are treating a moral and criminal cancer with iodine and eyewash.

As a former chairman of the National Association for Prevention of Addiction to Narcotics which had a fine research program but found private funds hard to come by, I know that the $7,500,000 appropriated in this legislation for care, treatment, and rehabilitation is likewise meager. There are estimated to be 100,000 known addicts in the country.

California alone appropriated some $8 million some years ago to establish facilities and support several ongoing programs.

I realize that money alone has no universal magic in this or any other field but we need resources to research as well as treat as thoroughly as we can these unfortunate people in society.

We must by our generosity encourage in every way the best brains and warmest sympathies in our scientific, medical, and social welfare fields to come into this vineyard of service to do a lifetime's work, if necessary, in a long neglected cause so closely related to so many other social, moral, and even economic problems in our society.

Let us begin strongly.

Before this legislation and its appropriation are finalized, I suggest you canvass the best opinions, especially, in New York City and State to determine their immediate and eventual needs in this area for this decade.

Personally, I believe we need a Federal, State, and city supported and serving facility in the metropolitan area of New York.

It is an old cry but it is nonetheless an insistent one.

Having a Federal hospital in Lexington where the rate of recidivism is as high as 95 percent has proven of little value.

We need a fresh start nearer the greatest concentration of addicts in the country—New York City.

Such a fresh start nearer the heart of the problem would underline the necessity of an overall, tightly integrated program with as much emphasis on aftercare as on hospitalization. Such a facility would provide the proximity necessary to closer cooperation and a more careful evaluation of this perplexing and costly problem.

I truly believe that if the Federal Government showed such an interest in a federally initiated facility in the metropolitan area that surrounding States, cities, and private foundations, too, would provide matching funds of some kind to help support and maintain the institution and the program.

It would, I feel, be putting good money in the right place at the right time. Otherwise, I fear we may be putting good money after bad.

Mr. HUNGATE. Following that we have a letter and statement by Richard A. McGee, administrator of the Youth and Adult Correction Agency, Sacramento, Calif.

(The statement and letter referred to follow:)

STATE OF CALIFORNIA,
Sacramento, July 22, 1965.

Hon. ROBERT P. ASHMORE,
Chairman, House Judiciary Committee,
Subcommittee No. 2,
Washington, D.C.

(Attention: Mr. Wm. P. Shattuck, Counsel).

GENTLEMEN: This is in response to your invitation received through Mr. Irvine Sprague, deputy director of finance, State of California, Washington, D.C., to testify before Subcommittee No. 2 of the House Judiciary Committee on a group of bills dealing with the problem of narcotic addiction.

Attached is a copy of a statement which I have prepared commenting upon the subject.

Mr. Roland W. Wood, superintendent of the California Rehabilitation Center for narcotic addicts at Corona, Calif., is prepared to testify before your committee on July 29. He is closer to our civil addict commitment program than any other person in the administration. He is authorized to present my testimony and enlarge upon it.

We in Governor Brown's administration in California are most interested in assisting in any way we can with the development of sound legislation in this field.

Yours very truly,

RICHARD A. MCGEE,
Administrator,
Youth and Adult Corrections Agency.

THE TREATMENT, CONTROL, AND REHABILITATION OF NARCOTIC ADDICTS

(Testimony relating to proposed Federal legislation by Richard A. McGee, administrator, Youth and Adult Corrections Agency, State of California)

The outline statement which follows does not address itself to any one of the specific bills before the committee but deals with subject matter pertinent to all of them.

I. SOME DOCUMENTED BACKGROUND FACTS

1. Narcotic addiction and other abuses of dangerous drugs are related to delinquent attitudes and behavior.

2. A combination of adolescent rebellion, subcultural deprivation, personal feelings of social inadequacy, delinquent and criminal associations, and the availability of illegal dangerous drugs is the soil in which drug addiction takes root, grows, and flourishes.

3. Most narcotic drug addicts begin using opiates between the ages of 14 and 20.
4. Most known addicts had some kind of police record before first using heroin.
5. The most common offenses for which male addicts are arrested are those involving some form of theft—forgery, burglary, car theft, and the like.
6. The active addict is the chief source of the spread of addiction—one addict on the streets will make several new ones in his career. He is the vector of the "disease."
7. Only a very few addicts will volunteer for treatment.

II. CONCLUSIONS

1. The old argument as to whether drug addiction is a medical problem or a law enforcement problem should come to a halt. It is neither; it is both—and much more. It, in fact, has many parallels in public health concepts. For example, a typhoid carrier may be placed under legal restraints, including confinement in a public institution; a recalcitrant tubercular may be forced to submit to segregation and treatment; the mentally ill person who is "dangerous to himself or to others," may be committed to a mental hospital. The Supreme Court decision in *Robinson* v. *California*[1] which held that drug addiction is not in itself a crime, made it clear that drug addicts may be forced to accept treatment and public constraints not as punishment but as a measure of public health and public protection.
2. The addict population cannot be brought under public control by present punitive methods applied to the addict. A new type compulsory program must be developed which includes confinement in rehabilitation centers and intensive postinstitutional supervision by specially trained workers, preferably with basic training in a profession based on social science, followed by specialized internships in the unique problems of supervising, managing, and treating the addict personality.
3. The administrative structure provided to direct a program to deal with civilly committed addicts should be a single entity—not a hodgepodge of police, jailers, probation officers, prison wardens, public health officers, and mental hygiene institutions and clinics.

Ideally a separate narcotic addiction authority might be created, especially in the jurisdictions with high concentrations of addicts. In California, the choice was made to place the function in the State department of corrections rather than in the department of public health or the department of mental hygiene. This was done because the department of corrections already had had extensive experience in handling drug addicts, however inadequately, and because it had a well-developed aftercare organization. However, the State supreme court decision in *In re Application of De La O*[2] admonished the administration against the "indicia of criminality" in the 1961 Civil Addict Commitment Act. Accordingly, the 1963 legislature removed the parole board for felons from the program and created a separate board called the narcotic addict evaluation authority. Also, insofar as possible all language associated with criminal procedure was removed from the law, and in 1965 the whole statute was moved from the Penal Code to the Welfare and Institutions Code. The civil addict program, however, will continue to remain as a separate administrative unit within the department of corrections. As a further safeguard, an advisory council of nine members appointed by the Governor, with a medical doctor as chairman, maintains general advisory oversight of the program.

III. RECOMMENDATIONS AND GUIDES FOR FEDERAL LEGISLATION

1. Civil commitments in the Federal system

(*a*) Eligibility of those charged with Federal crime should include any addict found guilty of any Federal offense except (1) a person guilty of a crime of violence (burglary and housebreaking should not be defined as crimes of violence unless a weapon was used); (2) a person guilty of any crime for which the minimum penalty is more than 5 years; (3) a person charged with selling a narcotic drug unless the court determines the primary purpose of the sale was to enable the person to obtain a narcotic drug which he requires for his personal use because of his addiction to such a drug; and (4) a person against whom is pending a prior charge on a felony.

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[1] 370 U.S. 660.
[2] 59 C. 2d 128; 378 P. 2d 793.

COMMENT

Previous civil commitments for narcotic addiction should not be made exclusionary except at the discretion of the court as many addicts, if properly handled in a good program, might be excluded arbitrarily and quite unnecessarily. One should remember here, too, that rehabilitation is not the only objective of this program—control and management of the addict as measures of public health and crime prevention are also important. Note, also, that we do not recommend exclusion of persons arbitrarily because of two or more previous felony convictions. "Felony" is so widely and differently interpreted throughout the country that this would result in a great many persons being excluded who might prove to be the best subjects for the program. For example, in California petty theft with a prior is a felony; walking away from a county jail camp is a felony; writing checks without a balance in the bank is a felony; and so it goes. It is assumed here that we are attempting to exclude only those who are primarily either dangerous or habitual criminals aside from narcotic addiction.

(*b*) Eligibility of those not charged with or found guilty of a crime. These should include any person found to be a narcotic addict who presents himself through appropriate channels for commitment for a period of treatment and rehabilitation who is not excluded under (*a*) above.

COMMENT

Such voluntary commitments should be for a fixed period or until discharged by the court. Otherwise, many will sign out against professional advice before treatment and a demonstrated period of abstinence has been completed. Volunteering into the program should be encouraged; volunteering out of it should be forbidden, just as the committed mental patient is not allowed to leave the hospital until the doctors think he is improved sufficiently to make such leave-taking safe both for the patient and the public. To encourage voluntary commitments the fixed period of treatment and control should be less than for the compulsory commitments. This is also justified on the basis that it is to be expected that the volunteers are more highly motivated in the initial stages of treatment. We would recommend at least a 3-year program for the volunteer commitments.

(*c*) Court commitments to the program of persons guilty of crime should be for a period of 7 years with provision for earlier discharge when the person has demonstrated rehabilitation by 3 years of drug-free and crime-free life in the community under outpatient supervision. California's experience would indicate certainly that the 3-year provision in current drafts of Federal bills is unrealistic.

(*d*) Persons charged with a crime not excluded by the act and believed to be addicts should be examined as soon after arrest as possible. Urine analysis is inconclusive 48 hours after injection of the drug and nallorphine after 3 or 4 days. There are, of course, other indexes of addiction, but they do not have the objective value of chemical tests if the addict does not exhibit obvious withdrawal symptoms and denies addiction.

(*e*) Such persons should be examined either by statutory mandate or by order of a magistrate—not as a matter of choice by the addict.

(*f*) In the case of persons charged with a crime and eligible for this program, the finding of guilt should be made and the proceedings adjourned before the imposition of sentence in order to interpose the civil commitment at a place in the criminal proceedings which can be easily resumed if the addict is returned to court later for discharge from the civil commitment either because of success or failure.

2. *Administrative implementation of rehabilitation programs for drug addicts*

(*a*) We suggest that the Federal Government establish 3 small institutions of about 300 capacity each: 1 in the New York area, 1 in the Chicago area, and 1 in southern California. These should have as their primary purpose the training of personnel in the techniques of treatment and rehabilitation of narcotic addicts. A strong program of research should also be authorized in these training institutions.

(*b*) Eligibility for placement in these facilities should be open not only to federally committed addicts, but, also, to cases committed by the State courts on a cost-sharing basis.

(*c*) We suggest that the Federal Government provide a system of subventions

to the States for the construction of facilities for programs set up under State laws. Lack of initial capital outlay funds is often the greatest obstacle to movement in States with growing populations and increasing strains on the revenue structure.

(*d*) We further suggest Federal subventions on a grant-in-aid basis for treatment-rehabilitation programs in State facilities, for personnel training, for research and, especially, for the aftercare supervision of addicts. Without these the new proposed laws will most certainly fail in their objectives.

(*e*) Since there are, and probably will continue to be, many more addicts in prisons and correctional institutions (Federal, State and local) than there are in programs for civilly committed addicts, it is also suggested that the Federal Government provide funds and standards for the establishment of treatment units in such institutions and for the specialized aftercare supervision of addicts paroled therefrom.

Finally, it should be said that there is strong feeling in the States, and especially in California, that the Federal Government should develop a better supported and more vigorous program to prevent the importation of heroin from other countries, and especially from Mexico. Without a ready supply of illegal drugs, narcotic addiction would dwindle to insignificant proportions just as it did during World War II. This, of course, does not diminish our support of an energetic and enlightened program of treatment, control, rehabilitation, and supervision of the many thousands of addicts now on the streets and in the institutions of this country.

Mr. HUNGATE. Also from California we have a statement of Roland W. Wood, superintendent of California Rehabilitation Center, Corona, Calif.

(The statement referred to follows:)

STATEMENT OF ROLAND W. WOOD, SUPERINTENDENT OF CALIFORNIA REHABILITATION CENTER, CORONA, CALIF.

The Honorable Robert T. Ashmore and members of the House Judiciary Committee, it is a personal pleasure and privilege to appear before you and to discuss the program, problems, plans, and findings of the program for the treatment of the narcotic addict under civil commitment to the California Rehabilitation Center, Corona, Calif. This facility in the youth and adult corrections agency, State of California, and under the administrative direction of the director of corrections, has been in operation just less than 4 years, having been created by the 1961 legislature and activated on September 15, 1961.

During this period, we have had committed to this civil addict program over 4,800 commitments, 4,069 men and 734 women. Our present (July 1, 1965) population at the center is 1,707 men, 277 women, and a felon work crew of 70 men who are engaged in the physical rehabilitation of the former surplus naval hospital buildings and grounds which was acquired for the permanent facility for the center on March 30, 1962.

It is my firm belief that in this 4-year period we have demonstrated that—

The addict can be successfully treated in nonpunitive setting; yes, even one which does control his freedom and does not permit him to leave the program when it becomes painful for him to look at himself.

We can return individuals for additional treatment where relapse into narcotic use has occurred but prior to serious readdiction or criminal activity.

We can successfully control the addict to prevent the spread of addiction by the contagious effect of the addiction process.

We recognize that a great deal must be learned about the addict through research; what makes him "tick," how can we best help him to help himself, and how can we best work with the families and dependents of the addicts.

The return to the community under close and careful supervision is an integral step in the treatment process; when carefully supervised by competent, trained and experienced agents coupled with antinarcotic testing, the individual can readjust to society and live drug-free in the community.

Efforts to treat the problem of addiction on a purely voluntary basis is not considered too successful treatment of the addict nor protection of society.

Perhaps, though, I am summarizing too quickly the results of our experience and you would appreciate a more detailed discussion concerning California's approach to the narcotic problem. Let me, therefore, discuss the various aspects of the program with you.

A great deal of concern was expressed, particularly in southern California, during the early part of 1961 about the increasing incidence of narcotic use, the need for stiffer penalties for users and sellers of narcotics, and the pressing need to provide a treatment program for those addicted. This new and research-based effort to control addiction was activated September 15, 1961. It provided for a program of civil commitments of addicts as recommended by Gov. Edmund G. Brown to the 1961 Legislature.

CALIFORNIA LEGISLATURE ESTABLISHES CIVIL ADDICT PROGRAM

The legislation as finally enacted drew on experience in the narcotic treatment control project and provided—

1. A civil commitment for treatment.
2. The California Rehabilitation Center.
3. A mandatory aftercare program, including reduced caseloads, anti-narcotic testing to determine narcotics use, and authorization for a halfway house.
4. A mandate for research into the rehabilitation of narcotic addicts.[1]

The program was made compulsory and a long period of legal control was provided for therapeutic reasons and after carefully evaluating experience here and elsewhere. Without a legal, enforceable commitment, a very large percentage of addicts will not undertake treatment. Given the opportunity, an extremely high percentage of addicts will leave treatment before this is medically indicated.

Without a legal, enforceable commitment, there is no way postinstitutional treatment can be insured. The lack of such treatment has been widely blamed for the high rate of failure in other efforts to control and treat addiction.

The commitment proceedings are essentially those employed for the commitment of the mentally ill.

Once the person is committed, he is committed for a definite period even though he may have actually volunteered himself for treatment. The law now provides for a 2½-year commitment for volunteers, and a 7-year commitment for those committed following a misdemeanor or felony conviction.

The first 6 months, however, must be spent as an inpatient. The former addict may then be placed in outpatient status. If he abstains from the use of narcotics for 3 consecutive years, he is discharged from his commitment and the criminal charges against him, if any, may be dropped.

The law provides return to inpatient status upon detection of narcotic use. It also provides that if the person is ineligible for discharge from the program, he shall be returned to court for imposition of the original sentence or, perhaps, for recommitment to the program. A graphic presentation of this is presented in the attached chart.

CHANGES IN THE LAW 1963 AND 1965

In 1963, the legislature amended certain sections of the law to place emphasis upon treatment, the nonpunitive purposes as far as the individual is concerned, and the prevention of contamination of others and the protection of the public thrugh control of those who are uncooperative or unresponsive to treatment. It created a new releasing agency, the three-member narcotic addict evaluation authority. It also established a nine-member advisory council known as the narcotic rehabilitation advisory council. his is a nonpaid advisory group whose functions are to render advice to the administrative authorities and to make certain that the program does not retrogress into a penal one, interpret program to the Governor, the legislature, and the public.

In the 1965 legislature just concluded, greater controls were placed on the growing menace of dangerous drugs and provisions were made for the detention of individuals who are believed to be addicted but who are not charged with a crime. These sections provide that "Any peace officer or health officer who has reasonable cause to believe that a person is addicted to the use of narcotics

[1] Ch. 11, title 7 of pt. 3, California Penal Code, amended 1963.

or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use may take the person, for his best interest and protection, to the county hospital or other suitable medical institution designated by the board of supervisors of the county."[2] Within 24 hours he must be examined by a physician and if found to be addicted he may be detained for not more than an additional 48 hours for further examination. It is expected that these changes will assist in the commitment of those individuals who need treatment, but could not previously be brought into the program because they were not involved in board of supervisors of the county."[2] Within 24 hours he must be examined criminal activity. It places the legal provision in the welfare and institutions code rather than the Penal Code. Thus it removes what has been referred to as "Unfortunate and unnecessary 'indicia of criminality' contained in the law as originally written."

THE PROGRAM BEGINS

When the addict is committed, he is received directly at the rehabilitation center and immediately assigned to a group of 60 residents where he will remain until he is returned to the community. Females are received in a separately fenced area of the center. Programing for the women residents is identical but it is completely separate and apart from the men's programing.

The initial diagnosis is undertaken by the psychologists and counselors who will continue to work with the residents. A variety of tests are administered, including IQ, educational achievement, vocational aptitude, and personality tests. The addict's social and criminal history is compiled. The counseling staff makes a special effort to develop his narcotic history. From this the staff develops a recommended treatment program.

The program for the nonfelon addicts is based on a continuous effort on both an inpatient and outpatient basis by trained staff to provide enough control to avoid damage either to the patient or society, but also leave opportunity for growth. The emphasis within the institution is upon the group or community living. This includes an effort to involve as much staff as possible as part of this community.

The living units, composed of 60 men, are the basic treatment groups. Transfer between units is discouraged. Individuals function and learn to live in their own unit—facing and working out problems as they occur. Large group meetings are held daily, 5 days per week and include all residents plus staff. This is patterned after the techniques found successful by Drs. Maxwell Jones and Harry Wilmer and discussed more in detail in their writings on the therapeutic community as it was applied to patients in mental hospitals.[3]

These large groups begin by discussing everyday problems of living in an institution. Gradually, the groups begin to consider such things as pilfering, informing, and other problems which might exist in the unit. They also eventually consider relationships with friends and family on the outside, and often come to grips with feelings about themselves and others. The large daily meeting is followed by a smaller meeting of staff to evaluate what happened and provide feedback to the next large group meeting. Two or three times a week, in addition to the daily large group meeting, the 60-man group breaks into four 15-man group sessions for an hour of more intensive group work.

For some residents the second half of the day is devoted to what might generally be classed as work therapy.

Others are assigned to school or to vocational training. There is a full academic program through the elementary and high school level.

The institutional treatment is only the first phase. The test comes in the community and only in the community. I should emphasize that we are not expecting to "cure" the addict. We are looking for signs that he has gained sufficient control of himself that he is worthy of an opportunity to test the strengths that he has gained. We will never know if he is not given the opportunity to test himself and certainly our experience has shown that excessive time in confinement does not bring about this desirable change.

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[2] Sec. 3100.6, Welfare and Institutions Code, amended, 1965 legislature.

[3] Jones, Maxwell, "The Therapeutic Community," a new treatment method in psychiatry, Basic Books, New York, 1953 (53–7402). Wilmer, Harry A., "Social Psychiatry in Action," a therapeutic community, Thomas, Illinois, 1958 (58–8436).

CHARACTERISTICS OF CALIFORNIA REHABILITATION CENTER ADMISSIONS IN 1964—MALE

1. *A young group.*—A median age of 25 establishes the California Rehabilitation Center residents as being about 4 years younger than felony offenders committed to California correctional institutions. Those under 21 account for 11.2 percent of those received.

2. *Inteligent.*—The measured intelligence of the California Rehabilitation Center residents is on the whole, slightly above that of the general population with most falling in the "normal" and "high average" categories.

3. *Need education.*—Over 50 percent of the population measures below the eighth-grade level. Thirty-one percent have a grade placement of 9.5 or better.

4. *Marihuana and drugs—Then opiates.*—Between the ages of 16 to 18 a large majority of the California Rehabilitation Center commitments experimented with marihuana and dangerous drugs. The use of opiates, especially heroin, occurred at about 20 years of age.

5. *Not necessarily delinquent prior to drug use.*—One-half of the California Rehabilitation Center group had no indication of an arrest prior to their first experimentation with drugs; 98 percent had no prior prison commitment before first drug use.

6. *Mostly felony convictions.*—Seventy-three percent of the admissions to the California Rehabilitation Center were committed following conviction on felony charges; 21 percent following conviction on misdemeanor charges; and 6 percent were committed without a criminal charge; 82 percent had no prior prison commitments.

7. *Narcotic convictions predominate.*—Seventy-four percent of the California Rehabilitation Center commitments followed conviction on a narcotic offense; 18 percent were convicted of crimes against property or persons; 6 percent had no criminal charge.

8. *Most commitments from Los Angeles County.*—Over 65 percent of the California Rehabilitation Center commitments were from Los Angeles County. Eighty-four percent were from southern California.

9. *Basically a California problem.*—More than one-half of the California Rehabilitation Center residents were born in California and 86 percent have lived in California 10 years or more.

CHARACTERISTICS OF CALIFORNIA REHABILITATION CENTER ADMISSIONS IN 1964—FEMALE

Data on California Rehabilitation Center female residents reveal some differences when compared with the male population. There is some evidence that there are somewhat larger number of voluntary commitments for the women as contrasted with the men. Also, the women are slightly older than the men with a median age of almost 26. They do differ significantly with respect to ethnic background with the largest group composed of the Caucasian white as compared to the males where those of Mexican-American ancestry predominate.

1. *Slightly older.*—The median age for women is 25.7 years. Those under 21 account for 8.7 percent of those received.

2. *Intelligent.*—The measured intelligence is slightly above the general population. Education ranges from fifth grade through college graduates; 23 percent tested at a school grade placement of 9.5 or better.

3. *Use of drugs.*—The median ages for first use of marihuana is 16.9 years; for dangerous drugs 18.4 years and for narcotics 21.2 years.

4. *Arrest History.*—About 95 percent had no trouble with the law as juveniles; 62 percent had no indication of arrest prior to their first experimentation with drugs. More than 93 percent have no prison commitment in their record.

CASEWORK CONTINUES IN THE COMMUNITY

The field (community) staff becomes involved with the resident soon after his commitment. The caseworker contributes an extensive review of the resident's home environment, family feelings and attitudes, work record, and prospects to the case history while the initial summary is being compiled. The caseworker may at this time make his first contact with the resident.

When the institution staff feels the resident is ready to leave, the caseworker to whom he will be assigned in the field contacts him. Together they work out release plans and begin to build a constructive relationship.

The caseworker is specially trained to work with addicts and his caseload of

30 are all addicts. The group work continues while the former resident is on outpatient status in the community. Each caseworker meets weekly with his caseload as a group. Counseling attendance is regarded as particularly important for those who are unemployed. Use is also made of the parole and community services division's outpatient psychiatric clinics where indicated.

The caseworker meets individually with each releasee weekly at his home or at his job. He also contacts others in a position to evaluate the progress being made—his family, his employer, the police.

In addition, each outpatient is chemically tested five times a month for at least the first 6 months. Four of these "nalline" tests are given on a regular basis, and one is a surprise test. If all the indications are good, this test schedule may be cut to two surprise tests a month after the first 6 months. Test failure or other indication of relapse to narcotic use results in return to inpatient status. We have recently added the use of urinalysis in the testing procedure, and our research is continuing to determine the best possible methods of early detection of reuse. On the other hand, many of our returnees are returned, not because they were using narcotics, but because they started drinking heavily or because they failed to maintain adequate employment or violated other conditions of their release. We look at some beginning delinquent behavior as a danger sign, and we bring him right back. The point is that a man's return to the Center is not failure. When a man goes out of the hospital after a pneumonia case, the doctor keeps his eyes open. If he sees a sign of relapse coming, he gets him back to the hospital. That is what we are doing. A doctor never really considers a tubercular patient cured. When they release them after hospitalization, they keep checking back, usually every 3 months, then every 6 months, and then every year. It is the same kind of control that we think we are dealing with in terms of the addict, and consequently a person who relapses is not seen as any more of a failure than a person who has to have further treatment for a tubercular condition.

Some of those who have returned have gone out convinced they "had it made." They encountered unexpected problems and reverted to narcotics use.

On return, instead of the bitterness and blaming of others that might be expected, counselors found an attitude of new appreciation of their problems and a new determination to lick them.

THE HALFWAY HOUSE PROGRAM

In May 1965 a halfway house program for males was activated in the metropolitan Los Angeles area. This facility, the Parkway Center, provides added short time support for 50 male residents in the community and helps to bridge the gap between institutional living and the full freedom of the community. Not only does the Parkway Center provide control and guidance for those released on outpatient status during the critical first phase of transition to constructive living in the community, but it also provides an opportunity to work more intensively with those individuals who may be making a marginal adjustment while on outpatient status. It can be halfway back to Corona for those who need this additional support.

It is expected that our halfway program for women will be open in August in the Hollywood area. The facility is about completed, staff selected, and a corps group of women designated to be the first residents of the Vinewood Center, which will eventually house 25 women. Since the female addict generally does not have the supportive family constellation to which to return, this is seen as a most valuable addition to our treatment facility.

WHAT HAS BEEN OUR EXPERIENCE WITH THE ADDICT WHEN RELEASED?

We do have some positive indications that the program is working and are encouraged at this point that we can make headway in returning men and women to the community where they can live responsible drug-free lives.

Since the beginning of the program in September 1961, there have been over 4,800 men and women committeed. As of July 1, 1965, there were 1,707 males and 277 females in the center. By June 1, 1965, 1,933 men and 492 women have been released to outpatient status in the community. Of those released to outpatient status 852 men and 236 women have been returned to the center for additional treatment. It is quite significant that of those males returned to the center only 10 percent were convicted of a new charge, while 90 percent were returned on the original commitment. With respect to the women, only 4 percent were returned with new charges. While it is too early to make any

predictions based upon these small numbers, the results are encouraging when it is recognized that one of the women has been out since August 1962, and will have completed 3 drug-free years in the community. She will be discharged from the California Rehabilitation Center program and many additional men and women will be eligible for discharge in the later months of 1965. I just recently received a listing of 104 names of individuals who have been out 18 months or longer.

We do have preliminary studies on those released from the California Rehabilitation Center on outpatient status and although they do involve only a small number to report major findings, some preliminary facts are available.

A report on the first releases during 1962 and covering 1 year of experience in the community, a total of 108 addicts, 52 men and 56 women, indicates that only 2 men had been convicted of a felony offense and 14 men and 2 women of misdemeanor offenses; and that 35 percent of the men and 36 percent of the women remained in the community with no evidence of drug use. That of the group returned to the California Rehabilitation Center, Corona, for further inpatient care, a little less than one-half of them were charged with opiate use and the remaining returnees were split 50–50 between no drug use and use of marihuana and dangerous drugs.

We as staff and society must learn to recognize that a return to the center for an additional period of treatment, perhaps once, twice, or three or more times should not be looked upon as failure. We must continue to offer the addict intensive, probing programs of counseling, psychotherapy and psychiatry. And our programs should not and do not stop when he leaves the center. We must continue to supervise, help, yes, even control the addict in the community; we must provide enough aid to bolster him over periods when society again, as it will, appears about to overwhelm him.

And when the addict has begun the reuse of narcotics we must promptly return him for further treatment aimed at making him fit for another opportunity back in the community. As Mr. Richard A. McGee, administrator, youth and adult corrections agency, has aptly put it:

"If society naively expects today's techniques to turn off addiction with a flick of a needle or a single dose of treatment, society is due for disillusionment. Society has to learn that an addict's problems are so varied and so deeply seated that repeated treatment may be necessary before he ultimately is free of his addiction."

NEED FOR AGGRESSIVE RESEARCH

Although there has been a great deal of interest and concern in research about addicting drugs, little is still known about the addict himself and we are prepared to undertake research along these lines. At the California Rehabilitation Center we have the unique advantage of having a specific mandate in the law for research. We are beginning to make some gains, but we see the need for well-structured research in the medical, physiological, psychiatric, psychological, and sociological aspects of narcotics addiction. Some of the questions we are prepared to ask ourselves sound like this:

1. Is there a specific physiological process which develops in narcotics addiction and is this process subject to control?
2. What is the nature of addiction, independent of the addicting agent?
3. Is there an addiction-prone personality and, if so, what are its dimensions?
4. What are the sociological factors in addiction; why do some social groups tend to have a higher addiction rate than others?
5. What is the relationship between narcotics addition and various forms of social maladjustment generally described as criminal?
6. What happens as a result of our community group approach? What is the nature of the process itself and what are its outcomes?

These and many other questions need answers before we can hope to "cure" narcotics addition. An important part of our task at the California Rehabilitation Center is to start answering some of these questions and to exploit the interest of others in an attempt to answer them. Our research budget, as such, is not tremendous, and we are going to have to rely on the interest of the major universities, the National Institutes of Health, and the large research foundations to undertake much of the needed research.

RECOMMENDATIONS FOR FEDERAL ASSISTANCE OR NEEDED LEGISLATION

I have been asked to comment regarding the needs which I see concerning changes in legislation or Federal assistance needed. I am cognizant of the fact that I must limit my remarks to those related to the control and treatment of the

addict rather than to the enforcement of the narcotic laws and its many ramifications of which I am not competent to speak. Law enforcement in its many subdivisions has been and must continue to carry out another very important phase of the control program for addicts. Efforts need to continue to control major suppliers of drugs coming into the United States, and the Federal Government plays an important role in this aspect. There are other areas, however, that I should like to comment on quite briefly.

1. Treatment centers should be developed with a nonpunitive atmosphere where the individual is under treatment and he is not permitted to leave at will, but must remain until such time as it can be reasonably assured that he will not immediately return to drug use.

Certainly our experience has shown us that for the most part men and women will not volunteer for treatment if they are not free to leave as soon as the initial discomfort of withdrawal has passed. In the California Rehabilitation Center program, one may volunteer, but after entry into treatment it is no longer voluntary. At the present time about 6 percent of the population are voluntary commitments. Treatment should be something more than an opportunity to reduce one's habit and then immediately be free to go back and pursue a course which leads to more severe addiction and criminal activity to support the habit.

2. Supportive supervision upon return to the community with return to the center for additional treatment if reuse of drugs is begun should be an integral part of the process.

There is no easy solution to the problem of narcotic addiction and, as I have previously mentioned, we cannot expect that an individual with evidence of serious maladjustment may be able to refrain from reuse when he again faces the pressures in the community after a short period of confinement and treatment. Like the alcoholic—and there are many similarities—he may relapse a number of times before he can become a useful citizen, husband, and father.

3. At Corona, we have capacity for 1,900 males and 400 females. In a month or so we will reach full capacity in our male units. While provisions have been made for temporary placement in existing facilities of the department of corrections at an institution at Tehachapi, we are desperately in need of additional space to house and program addicts who will be committed to us. The bureau of narcotic enforcement are identifying 200 new addicts each month which, of course, is related to the enormity of the problem and the growth of California. With the recent changes in the law, we have been advised that Los Angeles County alone will be committing between 30 and 50 additional addicts each month. To carry out the obligation expected of us, we must have additional space, and recruit and train personnel to program these individuals for return to the community. Preliminary investigations have located a surplus Federal facility near us and our application is in the final stages of preparation. To make this space available to our center would be of material and immediate assistance to the orderly development of our progress in treating the addict.

4. Modify the Federal statutes to permit a civil commitment procedure for addicts and eliminate the mandatory sentences.

It is impossible, or at least unlikely, to combine a punitive and treatment program in the same kind of treatment climate. Staff and those confined respond to the atmosphere created. California Rehabilitation Center is not a hospital nor is it a traditional prison; men and women are in a controlled drug-free ennvironment but in an atmosphere which is conducive to change in previous behavior patterns. An opportunity is afforded for him to look at himself; to examine attitudes, beliefs, feelings, and to be prepared to learn from mistakes so that ultimately he can make wise decisions about himself.

There have been a number of both men and women who have been committed to the California Rehabilitation Center who were under Federal commitment. Had it not been for the legal status requiring excessively mandatory terms, these individuals could have been assisted and released to the community under supervision. The research that has been conducted concerning the length of term indicates there is little relationship to lengthy sentences and the possibility of successful adjustment in the community. The experience gained thus far with the stiffer penalty imposed by the changes in the laws in 1961 indicates the district attorneys and judges are most reluctant to see 10- and 15-year minimums imposed and there is a tendency to accept alternate dispositions.

Without going into extensive discussion here, the merits of the indeterminate sentence with the judgment of the suitability for return to the community left with the judgment of a competent releasing authority far outweighs the sought-after protection to society that is hoped for with mandatory fixed sentences.

Readiness for return to society must be based upon changes that have been made in the individual rather than merely the expiration of a stated period of time.

5. A comprehensive plan of research should be developed covering all aspects of narcotic and drug abuse. At the salaries we are able to pay, it is difficult to compete with private industry to secure the best qualified personnel necessary to engage in research in this difficult field. The State of California has endeavored to make use of the knowledge and experience of those who have been working in aerospace programs for the Federal Government. Their initial report is to be completed soon and does indicate they have the expertise to assist in finding answers, but Federal funds will be necessary to augment those which can be allotted by the State. Some agency, such as the National Institute of Mental Health, should be provided with the necessary funds and the authorization to assist governmental agencies, universities, and competent researchers in a continuing, systematic evaluation of treatment programs, to seek out better treatment techniques, more scientific detection programs, and new ways of ending the traffic in narcotics. There is nothing small about the narcotics problem. No halfhearted program will solve it. The modest amounts that are included in the present State budget will cover only the barest of essentials. There is a vast warehouse of knowledge available if funds can be appropriated for this purpose. It boils down to this: Do we want to spend the funds for research and seek solutions or do we want to continue to pay the price in human suffering, crime, and programs of detention?

6. Increased programs of prevention aimed at the community where sources of infection are prevalent. Provide the public and professionals involved with accurate and factual knowledge on narcotic and drug abuse to combat the misinformation that is often prevalent. Perhaps, here again funds could be made available to NIMH to assist State, local, and private nonprofit agencies for demonstration projects looking exclusively to the development of informational and educational materials.

CONCLUSIONS

Controlling narcotics addicts is possible and a reasonably good job is being done in California with this phase of the problem. A description of the elements of the control and treatment program in the California Department of Corrections and the California Rehabilitation Center as well as the legal basis for the program has been given.

Much is being said today about control of narcotics addicts, but little with any finality about cures. Experience within the department of corrections in handling narcotics addicts has supplied no cures, but has not been completely negative.

The department of corrections, in the regular facilities of the department and in the California Rehabilitation Center, has thousands of narcotics addicts in its care. They must be handled now in the "best way possible" within the limitations of budget, physical facilities, and staff skills. Addicts who end up in prison and in the center have embraced a way of life which is largely foreign to you and me. In some cases, they may be escaping a situation they can no longer accept; in others, they may be seeking acceptance and companionship in the only place and circumstances where it is available. When mixed with other prisoners, addicts are generally looked down upon in the prison community. If allowed to meet together without proper leadership, they tend to discuss in great detail and relive their narcotics experiences on the outside. The "best way possible" to work with the addict in a controlled situation is (1) to insure a drug-free environment; and (2) to provide some structured experiences that utilize and capitalize upon his interests as soon as they become evident so that he begins to find new and hopeful directions to life.

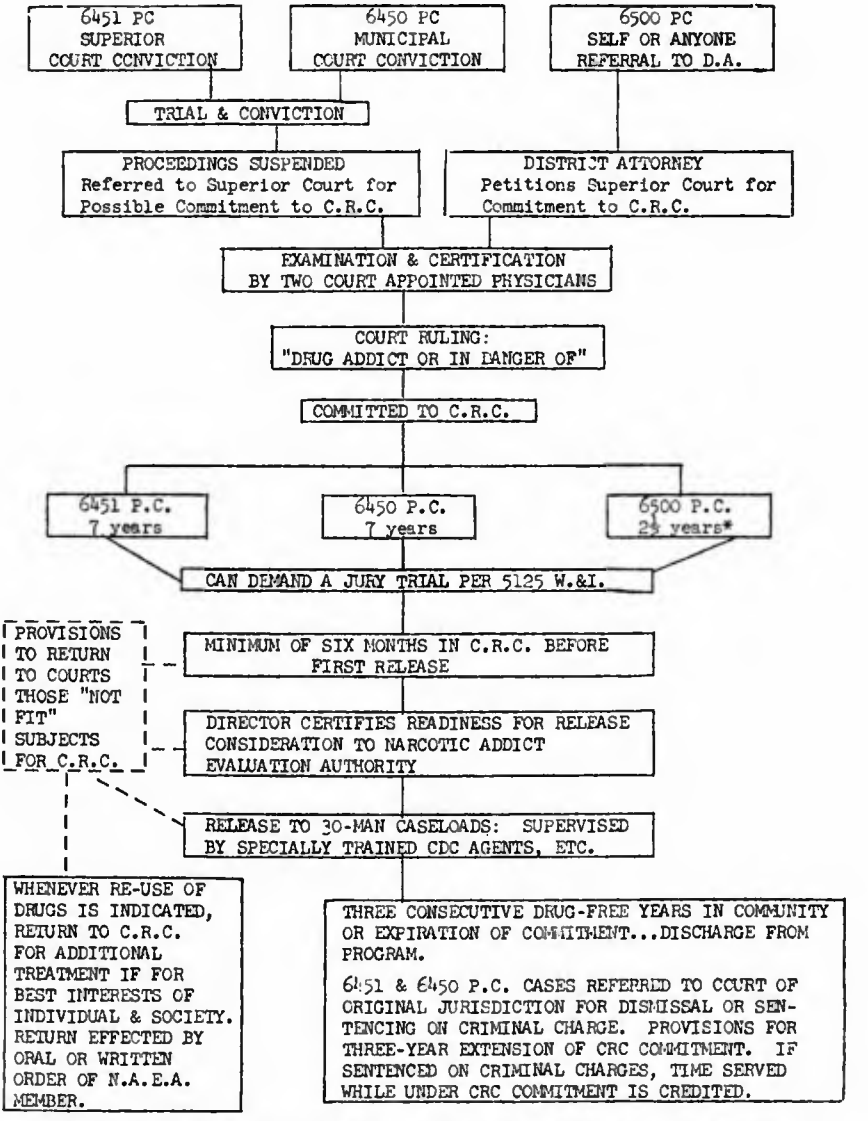
Somewhere along this trail is the honest encounter with himself, the desire and effort to hold a job, the discovery of some concern and feelings for others, and the thousand and one other characteristics which develop self-respect and make life worth living.

In effect, then, the California program is specifically designed to—

1. Get the addict off the street. Reduce their chances of contaminating other men and women with the same infection. Dries up the market for heroin peddlers.
2. Provides treatment for addicts.
3. Controls them when released to the community through intensive supervision and testing for drug use.
4. Returns them to the center for retreatment if they cannot adjust to the community.
5. Provides protection for society.

CALIFORNIA REHABILITATION CENTER - CIVIL ADDICT PROGRAM

LEGAL PROCESS



*Commitment is 2½ years for those who volunteer themselves for commitment; 7 years for those committed under this section upon the initiative of others.

Mr. HUNGATE. There being nothing further to come before the committee at this time, thank you.

Mr. KUH. If I may thank you again for the courtesies that you and the committee have shown.

Mr. HUNGATE. We shall now stand adjourned.

(Hearing adjourned at 3:40 p.m.)

HEARING ON BILLS PROVIDING FOR CIVIL COMMITMENT AND TREATMENT OF NARCOTIC ADDICTS

TUESDAY, JANUARY 11, 1966

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE NO. 2 OF THE COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2226, Rayburn Building, Hon. Robert T. Ashmore, chairman, presiding.

Present: Messrs. Ashmore, Gilbert, Grider, Hungate, Hutchinson, King of New York, McClory, and Senner.

Also present: William Shattuck, Esq., and Martin Hoffmann, Esq.

Mr. ASHMORE. The committee will come to order.

Subcommittee No. 2, House Judiciary Committee, is resuming hearings which we began last July, on the civil commitment, treatment, and rehabilitation of narcotic addicts. Testimony heretofore has been presented by Members of Congress, including the distinguished chairman of our committee, the Honorable Emanuel Celler, by representatives of the interested executive departments, private individuals, and Members of the House and Senate.

The position of the Department of Justice was ably presented by the Attorney General of the United States, and our purpose today is to receive additional testimony concerning this legislation from that Department, so that we can consider the departmental position in the light of the testimony which has been received in subsequent hearings.

We welcome this opportunity to gain a better understanding of the basis of the administration proposal and to draw from the experience of the two distinguished witnesses that we have with us today, in order to understand the practical aspects which bear upon the serious problems which this legislation is intending to meet.

Our first witness today is the Honorable Barefoot Sanders, Jr., Assistant Deputy Attorney General from the Department of Justice.

Mr. SANDERS. Mr. Chairman, I am here, of course, with Mr. Alexander, and we thought for the benefit of the committee we might just both be here together at the table, in the event there were questions I couldn't handle, Mr. Alexander could, and vice versa.

Mr. ASHMORE. We are glad to have two experts in to answer all of our questions.

Mr. SANDERS. Or at least both of us together might make one, Mr. Chairman.

I have a short statement here which I could either read or make it a matter of record. It consists essentially of a summary of the administration bill 9167.

Mr. ASHMORE. We will make the entire statement a matter of record, but you may read it or you may summarize, or just use your judgment, Mr. Sanders.

(The document referred to follows:)

STATEMENT OF BAREFOOT SANDERS, ASSISTANT DEPUTY ATTORNEY GENERAL

The narcotic bills pending before this subcommittee all represent innovative and ambitious approaches to the problem of narcotic addiction, with its ensuing criminal activity, social disorganization, and communicable effect. However, I believe that the administration bill, H.R. 9167, represents the best accommodation of the various problems faced in this area.

The objective of H.R. 9167 is to permit certain narcotic addicts charged with, or convicted of, Federal offenses to be treated as medical problems, with the hope of cure, by offering them programs of treatment and rehabilitation.

In brief, title I would establish a program under which a judge of a Federal district court, at an addicted defendant's first appearance, would be authorized to offer him an opportunity to be examined by the Surgeon General and, if he is found to be an addict likely to be rehabilitated by treatment, to be civilly committed to the custody of the Surgeon General for treatment of his addiction instead of facing prosecution on the pending charge. The defendant must elect within 5 days to participate in the program. The period of civil commitment, including both institutional and aftercare treatment, would be for a maximum of 36 months. The charge would be held in abeyance during this time, pending the successful completion of treatment. If treatment is successfully completed, the charge would be dismissed. If, however, before that time the defendant is found unresponsive or uncooperative, or the treatment fails, the criminal proceedings could be resumed.

Title II of the bill would establish a program under which a narcotic addict whom the court believes is likely to be rehabilitated could be sentenced to treatment following conviction. The sentence would be for an indeterminate time, not to exceed 10 years or the maximum sentence which might otherwise have been imposed, whichever is the lesser. After a minimum of 6 months institutional treatment, whenever the Attorney General and Surgeon General certify that release is warranted, the person would be eligible for conditional release on aftercare in the community. This determination would be made by the Board of Parole.

Both titles would establish programs of comprehensive treatment, including institutional care and aftercare. Both exclude those persons who are not deemed suitable subjects for rehabilitation or persons whose criminal activity warrants severe punishment. In this list of ineligibles are persons who sell narcotics for any reason other than the support of their own addiction, persons charged with crimes of violence, persons against whom are pending State or Federal criminal proceedings, persons who previously have been convicted of a felony on two or more occasions, and persons who have been civilly committed for treatment of their narcotic addiction under a Federal or State program on two or more occasions.

The Young Adult Offenders Act of 1958 extended the benefits of the Federal Youth Corrections Act to all persons who have attained the age of 22 and are under the age of 26 at the time of their conviction, except those convicted of certain narcotic and marihuana offenses and other designated offenses requiring a mandatory penalty. Title III would amend the 1958 act to remove this ineligibility with respect to the narcotic and marihuana offenses. In addition, it would amend section 103 of the Narcotic Control Act of 1956 to make parole available to all marihuana offenders and to those narcotics offenders sentenced under the provisions of the Federal Youth Corrections Act.

The problem of narcotic addiction has withstood our best efforts and has even flourished. It is a major source of crime in our communities and a continuing menace to our youth. We believe that H.R. 9167 constitutes a new attack on this individual and community threat. It merits a trial. It will afford treatment in those instances where it is most likely to succeed, while providing safeguards for the protection of the community.

Mr. SANDERS. I think I will summarize it, if it is agreeable with you, Mr. Chairman. H.R. 9167 has as its purpose the treatment and rehabilitation of narcotic addicts, which we believe is the best answer to this rather ominous social problem.

Title I sets up a civil commitment procedure which we do not now have in the law, and would provide for treatment up to a maximum of 36 months. Title I, with limited exceptions, would apply to persons who are charged with any Federal offense. If such a person were a narcotic addict likely to be rehabilitated, and so found by the court, he would be eligible for civil commitment.

Title II of the bill would establish a procedure through which a convicted person who is an addict and likely to be rehabilitated could be sentenced for an indeterminate period of time, not to exceed 10 years and not to exceed the maximum sentence which might otherwise have been imposed. And it provides that these people are institutionalized, and thereafter put under an intensive program of aftercare.

Essentially, title III amends Federal sentencing provisions to make narcotic offenders who are between the ages of 22 and 26, at the time of conviction, eligible for sentencing under the Federal Youth Corrections Act, which they are not now, and it would also make all marihuana offenders eligible for parole. It would not remove the mandatory nonprobation, nonsuspended sentence aspect of the present law in either case.

It would also provide for review the sentences of narcotic offenders and marihuana offenders who have been heretofore sentenced and were ineligible for parole or sentencing under the Federal Youth Corrections Act. In this way a determination could be made relative to the parole of previously convicted marihuana offenders and sentencing under the Youth Corrections Act of previously convicted narcotic or marihuana offenders who were in the prescribed age limits at the time of their convictions.

We believe that H.R. 9167 constitutes the best answer that we have been able to devise after some months of study of this community threat of narcotics and marihuana. It will afford treatment in those instances where it is most likely to succeed, while providing safeguards for the protection of the community.

I believe Mr. Alexander likewise has a brief statement, Mr. Chairman.

Mr. ASHMORE. Yes, Mr. Alexander. Mr. Myrl E. Alexander, Director, Bureau of Prisons, Department of Justice.

STATEMENT OF MYRL E. ALEXANDER

Mr. ALEXANDER. Mr. Chairman, members of the committee, the Bureau of Prisons is responsible for the care and custody of more than 21,000 Federal offenders of whom 18 percent are violators of narcotic laws. It is with respect to these and the 1,200 to 1,500 drug users who are committed each year, for all manner of criminal offenses, that I appear before you in support of H.R. 9167.

First of all we acknowledge that we have had too little success to date in our efforts to rehabilitate narcotic addicts. There are several reasons for this.

For one thing, the Narcotic Control Act of 1956 makes little distinction between drug users and drug peddlers, despite the fact that

the problems of treatment and control of these two types of offenders are quite different. We know, for example, that institutionalization alone is not the only means of exercising control. One of the areas of greatest weakness in our present methods is the lack of really adequate post release support and supervision of former addicts. We believe that the emphasis given this feature of the California program accounts heavily for the early successes they are claiming.

Effective correctional treatment operates within clearly and properly defined limits. I am very much concerned that our treatment of narcotic addicts is handicapped even further. Because of the provisions of existing statutes we have neither the flexibility nor the opportunity to apply correctional treatment on the basis of individual need. The result is that for many addict offenders personal achievement and rehabilitation are stymied. This provides no positive motivation on the part of the inmate. The timing and conditions of release have no relationship to individual progress and achievement.

The broad goal of corrections is public protection through the selective and flexible use of many resources designed for effective intervention in continuing criminal careers. Beyond the ineffectiveness of our correctional treatment of addicts, I am impressed that our present methods are inordinately costly. Unwarranted costs are inevitable whenever prison inmates are held in confinement beyond the point where institutional treatment and control are needed. I believe that we have been all too willing to provide little more than expensive long-term domiciliary care of addict offenders.

The time has certainly come when we should recognize these issues and try a different approach. This is the intent of H.R. 9167. As a prison administrator, I am increasingly impressed that the crossroads of correction is located in the criminal courts. It is here that early distinctions are made among offenders. It is here that, upon conviction, the choice of dispositions available to the court determines what numbers, what kinds, and for what purposes offenders shall enter the various components of our correctional system.

From my point of view, this is the central issue upon which the thrust of H.R. 9167 is focused. The provisions for civil commitment in lieu of prosecution under closely limited circumstances give the sentencing judge an additional dispositional alternative without detracting from the choices or power of the alternatives already available to him. The purpose is to provide effective medical treatment and control to those addict offenders whose criminal offenses are secondary to the acute illness of addiction when it is reasonably clear that these offenders are amenable to such treatment. In these terms, civil commitment is not "easier" or "softer" than commitment under sentence. It is a problem-centered device that actually will provide supervision and control for a much longer period of time than a short-term commitment.

Correctional treatment and control are reserved for the substantial numbers of offenders with histories of drug usage who will not qualify, nor particularly need, special medical care. Although, in a sense this leaves the "culls" to the correctional system, we can work with them more effectively than at present if we can be assured of greater flexibility in the use of resources than we now possess.

Thank you, Mr. Chairman.

Mr. ASHMORE. Thank you, Mr. Alexander. You used the phrase there, Mr. Alexander, of "public protection." Will you elaborate a little on that?

Mr. ALEXANDER. Well, as we view administration of our prison system, parole, and probation, this is the goal—public protection. Public protection incurs in a number of ways. And, in our prision administration we view our job as one of intervening in criminal careers, to stop criminal careers, to guarantee to the best possible advantage nonreturn of persons to criminal or delinquent behavior, and, in this case, return to drug usage and all of the attendant criminal activity that upon this.

Your committee and this Congress last session provided us with some of the most valuable new tools that we have in our business—work release, home furloughs, community residential centers. And, I am preparing a report which I want to send along to all members of the committee, of the whole Judiciary Committee, to acquaint you with some of the uses being made of this.

Up until the time we had this kind of tool, men could stay in institutions and would stay in until some magic date the sentence expired or parole was granted, and suddenly, overnight be out under parole supervision which really means one or two contacts a month with a probation or parole officer.

Now, we are building strong bridges, with intensive supervision out in the community working during the daytime, back to the institution in the evening, continuing education, training, gradual control, guidance, coming back to group sessions.

Now, this is the kind of protection that we think was contained in the mandate of 1930 by Congress when the Bureau of Prisons was created. This provides a kind of intensive social protection that was not available before.

Our goal in the Bureau of Prisons is to devise and apply the most effective means available to us, and this includes new experimental kinds of programs, and doing all that we possibly can, once a person has been found guilty of a crime, once he has been committed, to stop this recidivism, this in and out of prison.

This is really what we mean in the context of prison administration in social protection.

Another component obviously is when you have got a man in an institution, you are providing limited protection during the time that you have him there, but our goals extend considerably beyond that. And this is one of the problems we see with the handling of the addicts; the fact that they are committed, they are in the institution, then suddenly they go out.

We think it important that we be able to apply these new tools and these new techniques and this new kind of controlled supervision to them.

Mr. ASHMORE. I think probably all the committee recognizes that this is more necessary with addicts than with other types of prisoners. Would you say that with your experience?

Mr. ALEXANDER. I think it is very essential to addicts. It is also very essential—I hate to generalize and say it is more important than—for all other offenders. We have 12,000 offenders under 28 years of age. Many of them in their late teens and early twenties. We think

it is very important for them, too. But it certainly is important to the addicts.

Mr. ASHMORE. Is there any different type of supervision and control and care that you would recommend for addicts than what you have for the general prisoners—more frequent visits or something of that sort?

Mr. ALEXANDER. We would anticipate extensive use of the provisions of the legislation passed in the last Congress. That is, intensive supervision in and out of the institution toward the latter stages of the sentence, use of community residential centers adapted particularly for these people, including special psychiatric or psychological supervision or supervision by psychologists.

We would propose this kind of very intensive supervision, not now available at all. And we think that adaptation of the provisions of the new legislation could be made and should be made specially and specifically to addicts and their particular kinds of problems of return to the control and apprehension of returning to the group with whom they associated before. If they begin to lose out on a job——

Mr. ASHMORE. That is one of the problems.

Mr. ALEXANDER (continuing). And maintaining this kind of supervision is absolutely nonexistent at the present.

Mr. ASHMORE. Are there any such institutions or places of that type now in existence?

Mr. ALEXANDER. In California, yes, sir, Mr. Chairman.

Mr. ASHMORE. But the Federal Government does not have any?

Mr. ALEXANDER. The Federal Government does not have any at present. And I think it is not only important in terms of the control of federally committed offenders, but it is also important, I think, that the Federal Government experiment with and develop these kinds of demonstration programs with built-in research and evaluation. If we are not moving in the right direction, pull back and try a new method, and adapt the experience for demonstration and for States and local communities.

I would see this not as something which we would be doing solely and completely on our own, but in close collaboration with the National Institute of Mental Health, with State departments of corrections who are confronted by the same problems and perhaps do not have the volume that some of the larger States like New York or California have.

I think it is the kind of contribution that we in the Federal Government might well be making to the State systems.

Mr. ASHMORE. I am not too familiar with the legislation you refer to that was passed last year, particularly the details of what it provided or did not provide. But was there any such provision in this legislation to set up institutions of this kind?

Mr. ALEXANDER. No, sir, Mr. Chairman. The legislation of last year authorized the Attorney General to permit inmates to go from the institution to work in the community and return at night. It authorized the furloughs for purposes of deathbed visits, funeral visits, for specialized training, or for other purposes consistent with rehabilitation of an offender, and third, authorized the establishment of community residential centers. These are more popularly referred to and known as halfway houses.

But this legislation is applicable to all offenders and we are now developing first those for youthful or juvenile offenders, another type for adults, and under this broad legislation, the same provisions can be made and adapted specifically to the addict offender following release, if this is advisable.

Mr. ASHMORE. Does New York have a halfway-house method, Mr. Alexander?

Mr. ALEXANDER. Yes, they have a number of halfway houses for all correctional programs, and, I think, including some for addicts. Unfortunately, I am not familiar with that.

Mr. ASHMORE. Mr. Gilbert said yes.

Mr. GILBERT. Yes, I think they are more on a voluntary basis, rather than directly operated by governmental agency.

Mr. KING. I was going to say most of the halfway houses up in our country are good restaurants.

Mr. ALEXANDER. You have some very fine ones under the youth authority in New York.

Mr. KING. I was being facetious. We have a very nice restaurant in my district called the Halfway House.

Mr. ALEXANDER. Well, we have one we started here last August in the District of Columbia for juveniles and youth in which we serve no meals at all. We found it was cheaper to contract with a nearby restaurant out on North 12th Street than it was to try to operate our own.

Mr. ASHMORE. What do you think, Mr. Alexander, of the problems that we are confronted with when these addicts are released from prison and permitted—naturally, they have a right—to return to their home community and go back to the same old environment?

Do you know of any way that could be arranged to help them, encourage them not to go back?

Mr. ALEXANDER. This is indeed a real problem, Mr. Chairman. And it is one with which we are confronted with all types of offenders, certainly many youthful offienders who come out of the rotten core of the inner city, or indeed, who come out of a highly deprived mountain rural area someplace.

First of all, a part of an effective correctional program involves education, it involves vocational training, in involves placement where these skills can be used, it involves elevating sights and perspectives of individuals.

I do not like statistics, but our total Federal prison population in intelligence by psychological tests is precisely the same as the general population of the country for distribution of intelligence. But educationally, they are 4 and 5 years retarded. Ninety percent of all inmates committed to us—addicts, nonaddicts, have no employable skill in a day and a time when industries are seeking all kinds of skills for employment.

So in dealing with addicts, most of whom come out of the very same kind of low education, they are school dropouts, they are unemployables, they present this same range of problems. In dealing with the addicts, we need to apply these same correctional processes of education, of vocational training, of group therapy, group guidance. And then, through placement, whether in halfway houses or through work release, in the kinds of situations that will more nearly or much better

enhance their opportunities of adjustment than the old method of coming along saying, "Well, you have gotten along well in prison, you have done a little something in education, you have come along, we will parole you"—and then they go back to the same place.

In many instances, this will involve placement in situations more in keeping with the level to which they have been elevated during the time they have been in the institution.

Mr. ASHMORE. Now, some addicts are well educated, are they not?

Mr. ALEXANDER. I do not mean to create a utopian picture of this. These are difficult people to deal with and you cannot always get them placed in different situations.

Mr. ASHMORE. What is the Government's program with reference to placements? What do you do to place an addict when he is released? Is there any special consideration given to him?

Mr. ALEXANDER. At this time, no special consideration. He is given the same opportunities and same kind of services that we have had available. We have a staff of employment placement people, for example, people who are trained in industrial personnel guidance, who are located in strategic points around the country. These are financed out of the profits of Federal Prisons Industries. I should not anticipate the budget, but we are asking——

Mr. ASHMORE. We all are doing that.

Mr. ALEXANDER. We are anticipating tripling this number of people.

Mr. ASHMORE. Tripling—that is the placement personnel, the people who seek out and find places to put them?

Mr. ALEXANDER. That is right, and who follow up after placement in industry to see how they can get along with the foreman on the job.

Mr. ASHMORE. That is in addition to your regular supervisory people?

Mr. ALEXANDER. That is right, and who follow up after placement. This is in addition to the large corps of Federal probation officers throughout the country who give supervision.

Mr. ASHMORE. Do you have a request up on the budget for that?

Mr. ALEXANDER. Yes; this is in connection with the operating budget of Federal Prison Industries, a Government corporation, which is authorized to operate the industries in our Federal prisons. We do about a $50 million business a year and use some of the profits of this to follow up on vocational training and placement in the community.

Mr. ASHMORE. Would this be a good opportunity to do something in the Great Society program, and spend some money to help these people rather than some of the other programs that might not be so vital?

Mr. ALEXANDER. Yes, Mr. Chairman, we are working very closely with the Office of Economic Opportunity, and not only in terms of the Federal prison system, but helping evaluate many applications which come to OEO from States or local municipalities having to do with delinquency, criminality, institutions, also with the National Institute of Mental Health. The Office of Vocational Rehabilitation in HEW are working very closely with us in this area.

And I would agree, sir, that our job is not one which can be solved purely and exclusively by the Federal Bureau of Prisons, but that many resources of Federal Government which deal with transitional

field, the problem of criminality and addiction is not a simple unilateral problem.

Mr. ASHMORE. It involves the whole society as a matter of fact.

Mr. ALEXANDER. That is right. And in this field of human behavior, which is really what we are dealing with, the extremes of human behavior, we are extremely retarded as compared with the physical sciences. As someone asked me recently, How can you make this clear? The only way I knew to respond was to say we know how to put men in orbit, we know how to electronically survey the face of a planet but we do not know what to do with the kid next door who steals a car.

This is the tremendously challenging problem with which we deal and we need to call upon all of the skills in the new developing research in psychiatry, in psychology. The revolution going on in education is very close to our problem.

As I suggested in our statistics, a tremendous number of school dropouts come to us, and I agree that the approaches must be on a real broad basis, as far as the Federal Government goes.

Mr. ASHMORE. Gentlemen, do you have any questions?

Mr. GILBERT. I would like to take the opportunity to thank you, Mr. Alexander, for appearing before us this morning. The chairman made reference to the problem that has concerned me for a great period of time, and that is mainly the return of the addict to the community.

Under the legislation as proposed, do you believe, sir, that we can really do all these things that we say in this proposed legislation and then return this addict back to his environment from whence he had left to go to prison, and hope that he is going to adjust himself and not return back to prison as an addict?

Mr. ALEXANDER. My view, Congressman, is that in the great majority of these cases return to the same environment and community from which they came, this usually means the neighborhood.

Mr. GILBERT. Yes, a specific neighborhood.

Mr. ALEXANDER. It is almost certain to guarantee reinfection, I guess, to use a medical term. But the addict presents all of these problems that we are familiar with among juvenile and youthful offenders. To simply go to an institution and then try to place them in a different environment, without raising the educational level, without training, without their having been in group therapy to gain insight into their problems, and without any more than just the usual nominal supervision would almost be defeating.

Our position is that in order to place the person in a different environment or in a different community, we have many problems to resolve beyond that of pure addiction. And the placement in another community then, flows naturally through the kind of training that the man has had in the institution, the kind of intensive supervision with our guidance people, with community residential centers, with the use of work release, so that the natural development of the offender and his placement is away from the community.

I could not agree more heartily that to take a man and put him in an institution, whether you put them there 1 year or 15 years without any kind of real controls, supervision, and use of financial development, this cure within him is almost fruitless.

For example, an addict recently at the Lewisburg Penitentiary was a person who had above average intelligence, pretty high mechanical

aptitude, but educationally retarded. He completed 20 months of training in our dental laboratory where we have 25 highly selected inmates in training at all times. He returned as chief of a section of a dental mechanic laboratory in an eastern city that was 200 miles from where he had lived before.

Mr. ASHMORE. Was he placed there?

Mr. ALEXANDER. He has already been promoted on this job, instead of being unable to get a job. You see, while he was in the dental mechanical laboratory, he had first of all to elevate his education, some 6 or 7 years, to meet the minimum standards to get into this. During the period he was in training, he was under the training of U.S. Public Health Service dentists. He worked in the hospital. He attended group therapy sessions. He was quite a different guy.

Mr. ASHMORE. Did your placement people put him there?

Mr. ALEXANDER. Yes, but this is no difficult job for our placement people, Mr. Chairman, when you have a man trained and he has a certificate and license to practice dental mechanics, because we can place 25 dental mechanics for every 1 we are able to train.

Mr. ASHMORE. He volunteered to go there? There is no law to force him to go there?

Mr. ALEXANDER. There was no problem with him. We had no problem because there was a job. He had the new skill, he had the new motivation.

Mr. ASHMORE. Would you say that most of them who are cured, who have been treated and pronounced well, would voluntarily go to a new environment, if personnel was provided to seek out these places and provide them before they left there?

Mr. ALEXANDER. I think this is quite true, Mr. Chairman. First of all, the addict, like the delinquent kid, when he is in the institution says I am through with it, I never want to go back to it again. But if he is pretty much the same guy when he goes out, plus a couple of years in prison, he does not have the means of doing this.

One of the important motivating factors with these people is that they progress with this training and then reach the logical point of release, that they still have to stay on 2 and 5 and 8 and 10 years longer, and this is what happens when parole is not available or when there is a long sentence. They begin to lose motivation and interest. Or there is difficulty in motivating them in the first instance. They say well, all I can do is just do this long sentence and go out.

Whereas, under more flexible provisions, for example under the Youth Corrections Act which this legislation proposes to make applicable for those under 26, because of motivation the likelihood of success is much greater than otherwise.

Mr. GILBERT. I am very impressed with what you have just said because this was more or less my feeling. That is why I guess maybe you impressed me. As I said earlier, this has been a great concern to me.

Now, under this new legislation last session that was passed, where you have an opportunity to release the prisoner into the community, when you say release into the community to work in the community, do you mean the community as it relates to the prison in which the inmate is incarcerated, rather than the prisoner leaving say Lewisburg, and going up to say the city of New York for training? If he came

from the city of New York, he is in that locale I would imagine where the prison is located; is that correct?

Mr. ALEXANDER. He may be in any 1 of our 35 institutions throughout the country.

All offenders are committed to the custody of the Attorney General, who has authority to transfer to any institution. In implementing this legislation, and remember we have only had 3 months' experience although we have been planning for it, we have designated specific strategic institutions throughout the country for use of this program.

For example, to use an institution not near any metropolitan area would be pretty foolish for us. We could put them out chopping wood or we could put them in a few light industries. But in a large prison industry of metal manufacturing where we train in many skills needed in much of industry now, when he reaches the level of training, he then may be transferred to Danbury, Conn., to Dallas, Tex., up near Seattle, to Terminal Island, Calif., and we are implementing this program through the use of our total resources. Not in terms of just which institution a man happens to be in initially.

Secondly, the bill provides and authorizes the Attorney General to establish community residential centers for service of sentence. And so we will be developing adult centers in communities in which the man will go out and work and come back to this center. The success of all of this is dependent upon the ability of our staff, our psychiatrists, psychologists, caseworkers, and our good solid prison people, to screen these people.

And, believe me, we have got backed up in Atlanta and Leavenworth, and some of our other places, the kinds of people who will never get within a mile of this kind of a program.

But for those who are motivated, who are interested, who make the development and progress, we have the flexibility now to develop these resources any place that they may be needed in the country.

Mr. GILBERT. Does the prisoner return every night to a prison?

Mr. ALEXANDER. Yes; or if he is working at night, every day, in his nonworking hours. And he returns not to come back and lie on the bunk. I will not permit his just going out to work and then coming back. He continues his education.

In Milan, Mich., recently, where we now have 30 men out on work release, half of those men had not completed high school work before they went on the program. They became metal finishers. They became drill press operators, they are trained in shearing machines, whatever this is in the metal industry, but they lacked two or three or four units of completing high school. They come back and go to high school at night. Some of them coming back from that metal factory are learning skills that will pay higher wages than when they started on work release.

Mr. KING. Will you yield just a minute?

Mr. GILBERT. Just a moment. Does he work with people that are individual citizens of the community?

Mr. ALEXANDER. Oh, sure, he goes out and works just like anybody else.

Mr. GILBERT. Under this program?

Mr. ALEXANDER. That is correct.

Mr. GILBERT. And does his coworker know that he is under this program while he is working with them?

Mr. ALEXANDER. In most instances he does. We advise them to make known who they are and what they are. This whole business of concealing the fact that you have a criminal record, I think, is self-defeating. I think it is the reason a lot of people get back in institutions. They try to conceal a fact of life.

Mr. GILBERT. One of the reasons I raise this question—and I will yield to you in a moment—is that in the city of New York there was a rabbi and a minister or a priest, I do not recall exactly, that on a voluntary basis decided they were going to operate a halfway house: an institute or place where a narcotic addict could come for some relief of some kind. And they opened in this more or less residential community, as I recall. Well, as soon as the community got wind of this, there was a tremendous uproar and they were out there picketing and they said we do not want these addicts in our community. they are going to infect our children, they are going to infect everybody in the community.

And, as a matter of fact, there was hell to pay there. And they were practically driven out of the community. But by sheer will power and guts these two individuals stayed there.

I wonder if you find that under your program you have had some similar experiences?

Mr. ALEXANDER. No, sir; because we do not put this program in a community until we have met with representatives of the community. and this usually in every instance involves the police department. They know exactly what the proposal is, how it will work; labor unions. As a matter of fact, the legislation requires, and I think properly so that you cannot put these people working in a community. for example, where there is unemployment or injecting them into what the union people call a scab situation, underpaying.

Before we put a man in any community, we meet with usually a group of 10 or 12 or 15, representatives of people; a cross section of the community. And it is announced in the papers. It is known.

Any time you put these people in a situation that is secretive or what not, you are almost guaranteeing trouble. Incidentally, more than half of the placements of our inmates now, and this is only, again I repeat 3 months, and we have over half of these placements have been made by business agents and representatives of unions. The union people are supporting us.

We would never put a single inmate in a community where the chief of police, for example, objected strenously to it. But bringing these groups together, sitting down, explaining the philosophy of the program, the merits of it, the fact that it is experimental, the fact that we are studying it carefully, has gained support for it.

I personally am opposed to any program that is secretive and that the people of the community did not know about. As a matter of fact, it is foolish to try it. Our experience is we get support beyond what we would ever have expected. There is something in human nature that if a program looks positive and affirmative from the interest of the community, you get support.

Mr. GILBERT. I yield to my colleague.

Mr. KING. I just wanted to bring out a point, Mr. Alexander. I admire you and the position you take; you and I are good friends. But we are talking about two different things here.

You are talking about the rehabilitation of people who have been sentenced to a Federal institution. The main feature of this bill as I understand it is to try to save these innocent narcotic victims, the first time or second time they are picked up, the users, and try to get them out of the habit of using drugs.

Title I of the bill contains a whole lot of exclusions, which would exclude most of the people you have been talking about, would they not?

Mr. ALEXANDER. I think that is quite right. But I think, Congressman King, that the types of programs which we are now developing and which we propose to use for the convicted addict, must also in almost all instances be applicable to civilly committed addicts. To attempt to cure an addict purely by a medical process will probably miss the boat in most instances.

Many of these cases that would be elgible for commitment, civil commitment, will be those in which the offenses charged are check forgery, stealing from an apartment house letterbox, this type of thing. Some of the offenders would be placed on probation because the offense charged seems to be minimal, a $45 check or something of this sort. If committed they might be committed for a year and a day, 15 months. Under the provision of civil commitment it will be for 24 months.

Mr. KING. Does it not exclude on page 15, a person who with intent to commit any offense punishable by a term of imprisonment for more than 1 year?

Mr. ALEXANDER. Not 9167 as I understand it. It excludes four types. One, persons charged with crimes of violence; second, persons charged with sales other than to support their own addiction.

Mr. KING. Let us stick to the violence first, under subdivision (b).

Mr. SANDERS. If I may pitch in a little bit on that. Subdivision (b) on page 11, if I am looking at the same copy. You are talking about the commitment after sentence and the exclusion?

Mr. KING. Under definitions.

Mr. SANDERS. And crimes of violence. And that is assault with a dangerous weapon or intent to commit any offense punishable by imprisonment for more than 1 year. The intent of that language is anyone who uses a dangerous weapon.

Mr. KING. He is the one you are excluding?

Mr. SANDERS. Yes, sir; with intent to commit a felony among other exclusions. The crimes of violence are not going to play a tremendous part because most of the people we are going to be dealing with are not going to be involved in crimes of violence.

Mr. KING. This would not be under Mr. Alexander's supervision anyway, because he is in the Department of Prisons and these people would be committed under the Surgeon General.

Mr. SANDERS. Well, the civil commitment people will be committed to the Surgeon General. Those who are committed after conviction will be under Mr. Alexander's supervision.

Now, I do not think—well, to turn it affirmatively, those who are civilly committed and under the care of the Surgeon General, we would

hope and we believe and it has just got to work this way, the Surgeon General and Mr. Alexander in supervisory aftercare have to work together.

We do not propose by the establishment of a civil commitment procedure to set up two separate entities, so to speak, one a civil commitment aftercare and another a criminal commitment aftercare. They will dovetail in together. Is that not the way you envision it?

Mr. ALEXANDER. Yes.

Mr. ASHMORE. That is the question I had.

Mr. ALEXANDER. As a matter of fact, Congressman King, for the past year, we have been in continuing joint studies with the Public Health Service, not only on this question, but also on others in which we have very close relationship.

As you know, the Public Health Service with whom we have worked for 35 years administer all medical, psychiatric, and psychological programs. Many of their staff are virtually Bureau of Prisons people. We see pretty much eye to eye on these problems. Administratively, the management of the civilly committed addict or the criminally committed would make use of many of the same resources.

Mr. ASHMORE. Under the law at present, would it be necessary to put in this language, a provision stating that those people committed to the Surgeon General for treatment, the civil commitment people, that they would be automatically supervised by you, by Justice, as they are released?

Mr. ALEXANDER. I do not know whether this would be wise as a mandatory provision, Mr. Chairman.

Mr. ASHMORE. If you do not, you are going to have to set up some administrative office for the Surgeon General to supervise them.

Mr. SANDERS. When the Surgeon General determines that a civilly committed person has had enough institutional care he has authority under the bill to release him to a supervisory aftercare authority.

This might well be the Bureau of Prisons or it might be a State system where they have one.

Mr. ASHMORE. Is the bill clear now as to those provisions or should we put something in there to clarify that point as to whom he would go and under whose supervision he would be when the Surgeon General releases him as cured?

Mr. SANDERS. It would be my judgment, Mr. Chairman, that it would be better to leave it open so that the Surgeon General can take advantage of whatever supervisory aftercare authority is available in a particular area, rather than restrict him to the Bureau of Prisons, a particular State authority, or to some other fixed entity. All of these are available under the bill as drawn.

Mr. ASHMORE. He can under the bill?

Mr. SANDERS. That is our judgment, Mr. Chairman. Yes.

Mr. ALEXANDER. And I would concur with that, Mr. Chairman. I am sure there will be many instances in which the Public Health Service with its tremendous resources will want to work cooperatively in establishing a community based program with a State or a city that has a problem and can generate resources and programs in that

city that otherwise would not be available to the State and the city. We would have a concurrent interest in that, too.

Mr. GILBERT. What is the percentage, Mr. Alexander, under the present law, of addicts that return to prison?

Mr. ALEXANDER. I simply do not have that statistic. I suppose until we get full data processing, it is going to be pretty difficult to follow those careers, particularly when so many, over half of them, are not committed for narcotic offenses.

But, certainly, it must run very high. Three-fourths, perhaps, but that is a guess.

Mr. GILBERT. Since we are in the realm of speculation, I am inclined to agree with you that it is quite high. But whether that has been for a narcotic crime itself, or a crime arising out of the fact that the individual uses narcotics. I would say that it still runs about 75 to 80 percent.

Mr. SANDERS. If I might add something there, Congressman. It does not directly answer the question but relates to it somewhat. We have information that of those who are narcotic offenders, that to be committed for a narcotic offense, we know something about their record. And about one-half of them have either one conviction or no prior record and the remainder have two or three or more prior felony convictions.

Mr. GILBERT. Then it is your considered judgment if we were to adopt this legislation that this percentage would be markedly decreased?

Mr. ALEXANDER. It would give us hope. The means of working with them in highly experimental programs. I think we have to recognize that these will be experimental programs. We have no basis on past experience of success. I think one of the earmarks of this new program must be one of continuing evaluation—or call it research or what you will—with an administrative will and capacity to change, to shift, to try new programs, whether it is as California does, yanking them back in for testing to detect whether they have used narcotics or not.

It is a critical social problem, and one in which we have to apply all of our known skills and continue to develop new methods if we are really ever going to solve the problem of the addict.

Mr. GILBERT. Probably in the area I represent in New York. I think the traffic in narcotics, the use of narcotics, is as high or higher than almost any other area in the country.

Now, this I find is true in the areas where you have people in low economic standard of living. These are the people with all the ills of society and all the social problems that, of course, are attendant with their low economic status.

That is why I want to get back to what I said earlier. If you are going to return this man back to his environment, and that is whether he served the term in prison or whether he is under a civil commitment, I think the whole program is going to be self-defeating—unless something is done within the community itself to eliminate these areas of poverty, to eliminate the low economic status of these people, and the hopelessness of these people.

Otherwise, I think you are going to have a very small percentage that might be saved under a program of this nature.

Mr. ALEXANDER. I certainly agree with you, Congressman Gilbert. We are not proposing that this legislation will solve the problem of narcotic addiction because the roots of it lie deep within the community and deprivations, economic, cultural, are recognized. But from a standpoint of the Department of Justice and our program of the Bureau of Prisons, we are very much concerned about programs which will successfully intervene and in those who have already become addicted, and I would concur with your heartily, that no matter what we do, if you drop the fellow right back in the same alley, in the same neighborhood, you are defeated almost before you start.

Mr. GILBERT. That is my feeling.

Mr. SHATTUCK. Is it not normal for these individuals to go back to their own environment?

Mr. ALEXANDER. Normally, yes. Our job under these new developing programs is to change the normal, what has been the normal.

Mr. ASHMORE. If that is without a placement program it is fruitless.

Mr. ALEXANDER. That is right; plus carefnl, intensive supervision and guidance. Many of these people, you know, can be brought up to an educational level beyond any they may have aspired to before or had. You can give them a work skill and they go out and one of their problems is how to get along with people.

We have found this in our pre-release guidance centers for youth offenders operated experimentally for the last 3 or 4 years. The fellow goes out and the first time the foreman tells him to "Look, get over here and get on the job over here," he turns around and asks, "Who are you to be telling me?"

This is why we have guidance people working with the personnel directors of plants and with groups of men having the same kind of problems back at the institution at night or at the residential center, sitting down discussing how do you get along with people, why do you react this way.

If you have group guidance people and individual guidance people it is a long row to take somebody who missed out in this transition from childhood to responsible adulthood, because of deprivation, because of whatever it may have been, and it usually happens in the situation Congressman Gilbert describes, it involves training, it involves education, it involves placement, and then it involves careful followup and supervision.

Mr. ASHMORE. How do your people, your probation officers, work with local State probation people? It occurs to me that after you place these people, that there has got to be cooperation between the State probation supervisory officers and these Federal prisons, because it would take a tremendous sum of money to establish a Federal supervision throughout the country, where the people might be placed.

Do you have good relationship with the various State probation officers?

Mr. ALEXANDER. Well, Mr. Chairman, this varies, of course, from section to section of the country. There are States and sections of the country that have virtually no probation or very limited amount of probation. We agree with you on this. Our present release guidance center in Detroit, Mich., again established about 3 years ago, is operated jointly both as to financing and to staffing with the

Michigan State Department of Corrections, and with the Wayne County Probation Department and our Federal probation office. It is a joint enterprise.

Here is our pre-release guidance center in the District of Columbia, it is being operated jointly with the District Department of Corrections, the U.S. Probation Office, the United Planning Organization. We have supplied staff who have had experience in our other places and gradually over a 1- or 2-year program, we will gradually withdraw from this, once our experience has been gained and applied.

This is one of the ways in which I am convinced you give Federal support and help can be given by working jointly in communities or States that look forward to this. We were authorized in our last appropriation to establish two more pre-release guidance centers. We are establishing one now in Kansas City in which we are working closely and jointly with whatever the department in Missouri has to deal with youth delinquency.

I think you put your finger on one of the major problems in dealing with crime and delinquency. That it is a broad community-based kind of social problem that flows out to a national problem. We cannot do this independently as a Federal agency insulated and isolated from it.

Mr. ASHMORE. Would you agree with me that a man, a former addict, a cured one who has been treated, that he should not be placed in any area unless there is proper supervision for him either the Federal or State Government?

Mr. ALEXANDER. Oh, absolutely, and by proper supervision, much more intensive supervision than that which is normally given to a released man.

Mr. ASHMORE. By proper supervision, I mean for addicts, before they would let them out.

Mr. ALEXANDER. That is right.

Mr. GILBERT. One more question. The chairman went into part of it. I think earlier in your statement you made some reference to the Office of Economic Opportunity, that you had been working with them.

I am very happy to hear that, because I think this goes back more or less to the nub of the problem and the core of the problem, since the Office of Economic Opportunity is located in the areas where you have this poverty.

And I wonder what kind of discussions have you had with them relative to this problem. Are they that you are going to cooperate with one another? You are going to set up parallel programs; joint programs?

Mr. ALEXANDER. I think I can answer this best by a specific example. Last spring a new director of corrections for the State of Kentucky, a man whom I have known for a number of years from another State, came in and said they had problems in Louisville, in Appalachia, and Hazard County, Ky., where they have no correctional facilities at all. How can I do something about this? What can the Federal Government do?

I said, "Look, you are right in an area in which I think the Office of Economic Opportunity might have some very real interest." We went with them to the Office of Economic Opportunity. Within 90

days there was established in Louisville, Ky., in one of their institutions, a youth institution, and in the coal mining section in Hazard County, Ky., a treatment and supervision facility on a demonstration basis.

I loaned them the services of some of our people. I do not know whether I did it legally or not, but I loaned them some of our people for a period of a month or two to help establish these. They are ongoing now. They are being supported very adequately by the Office of Economic Opportunity, and now I am sending some of our people in to see what they are doing to learn from this experience.

Now, this is an isolated specific example. But on broader scale, with OEO, and with the Office of Vocational Rehabilitation, are now establishing nine saturation programs dealing with delinquents and offenders and predelinquents in vocational testing, training and placement, and supervision. It is hard to isolate something in which the Bureau of Prisons and just OEO are working together, because usually this involves also the Department of Labor, their employment placement service, their youth services, Office of Vocational Rehabilitation, and frequently the National Institute of Mental Health.

Increasingly, I view the work of the Bureau of Prisons as that of a coordinating agency in these fields. And while we have no direct legal responsibility for prevention programs in the community, how else can we do our job from the long-range perspective unless we do become interested in prevention and provide a catalyst for this to be done?

Mr. GILBERT. Thank you, very much. I think this type of legislation and cooperation between all the Federal and State agencies is one of the great hopes of the future for the cure and care of narcotic addicts and all the related problems.

Mr. HUNGATE. Mr. Chairman, you have touched on a part of this that concerns me, with the close followup and treatment in the administration of the law. And along that same line, discussing the Office of Economic Opportunity and the Labor Department, I think some of us have had experiences that have caused some concern as to administration of the poverty program. I am talking about administration and centralized responsibility. I am interested to know whether there is any suggestion you would have as to who would be responsible.

In other words, if you wanted to write about a certain problem in connection with this program, you might want to be sure that you would go to the Bureau of Prisons, to the Surgeon General, or to the Attorney General, whoever it might be, but that you would not go to the Department and find out that it is being handled through the Labor Department or that they are handled through Mental Health.

What I am after here, we are all against centralization, but I would like centralization of responsibility and wonder what your thoughts are on what organization, what department could best be selected to bear the centralized responsibility for the administartion of this program and what guidelines, if any, Congress might give toward the drafting of legislation for the administration's program.

Mr. ALEXANDER. In my view, with primary responsibility provided in the act for Public Health to handle the civilly committed, for the Department of Justice administering the program for the criminally committed, and with the close coordination that exists between us,

the prime and central responsibility should rest pretty much as placed in the bill, and that our responsibility be that which we are developing now in the use of all of these many resources.

Mr. HUNGATE. Let me see if I understand the term instead of the bill there. The civilly committed, this would be the responsibility of the Surgeon General. Do I read that correctly?

Mr. ALEXANDER. That is correct.

Mr. HUNGATE. And the criminally committed, would be the responsibility of the Department of Justice?

Mr. ALEXANDER. That is correct.

Mr. HUNGATE. Now, we are talking about 9167?

Mr. SANDERS. That is right.

Mr. HUNGATE. And would that perhaps then become the responsibility also of the Surgeon General insofar as treatment was concerned?

Mr. ALEXANDER. For the criminally committed?

Mr. HUNGATE. Also for the criminally committed.

Mr. ALEXANDER. No, sir, that would be the responsibility of the Bureau of Prisons, but we would have available to us, even as we have now, the resources of the Public Health Service.

As a matter of fact, all medical, psychiatric, dental, environmental, sanitation programs within the Bureau of Prisons are administered by Public Health Service. We have this long history of extremely close cooperation and coordination.

As a matter of fact, we are now instituting a complete restudy and reevaluation of all of our medical psychiatric programs, jointly with Public Health, and this includes treatment of addicts.

And I can do no more than document that for 35 years we have had this kind of close working relationship.

Mr. HUNGATE. You highlighted what concerns me in the bill, that the important thing is the followup and the administration of the aftercare program.

Mr. ALEXANDER. Yes.

Mr. HUNGATE. This is the heart of the program. And I think this is the heart of the program in the closely related area of OEO.

I am therefore concerned about, the actual administration of the program. If there are any specific guidelines which can be followed in this type of activity, I suppose with 35 years of experience of cooperation you have some basis for predicting who the program could involve; is that what I understand?

Mr. ALEXANDER. That is with Public Health Service, and a growing similar kind of relationship with the other agencies of Government that have programs and resources that are tangential to the central problem we have at least.

Mr. HUNGATE. Thank you.

Mr. GRIDER. Mr. Chairman, I would like to direct a question to Mr. Sanders. And this relates to title II. As I understand title II, this would apply to people already in prison, who are serving sentences now.

Mr. SANDERS. No, sir. Title II applies this way. If someone is tried and convicted of a Federal crime in Federal court and it is determined that he is an eligible offender, that is, he is an addict, he is likely to be rehabilitated, he is not ineligible because he has been convicted of a crime of violence or has two or more previous convic-

tions, he is sentenced to the custody of the Attorney General for treatment.

Now, he would be sentenced for an indeterminate sentence, not to exceed 10 years, and not to exceed the term which he might have received, and he must be institutionalized for a minimum of 6 months.

It applies, then, to those who are convicted, but have not been sentenced. Presumably you can now do this to some extent, although not within these well-defined limits.

One of the reasons we did this is that we have no way of providing aftercare for those persons who are released from prison also we have no way of imposing a 6 months' minimum and indeterminate sentence.

Mr. GRIDER. Well, now, what would prohibit an attorney from going into court where a man has been previously sentenced and establishing that he was eligible under section (f), and getting a determination by the court that he was eligible and having him put under treatment?

Mr. SANDERS. After he had been convicted and sentenced to prison?

Mr. GRIDER. After he had been in prison for a couple of years.

Mr. SANDER. Commitment under title II is the result of sentencing to treatment under that title. If the person had already been sentenced, I don't believe the judge could substitute sentencing to treatment for the previous sentence.

Mr. GRIDER. This was not the intention?

Mr. SANDERS. Not necessarily.

Mr. ALEXANDER. That is right.

Mr. GRIDER. That is all.

Mr. SANDERS. Excuse me. If I may argue on that just 1 minute. I do not think we could turn around and apply this law itself to those who had been previously convicted. Is your question what would happen if after the law went into effect, someone were convicted and came in a year or so later and asked to be considered as an eligible offender?

Mr. SHATTUCK. Mr. Sanders, would he not have to be an addict within the meaning of the definitions?

Mr. SANDERS. Yes, he must meet all of the bill's requirements.

Mr. SHATTUCK. Would this provision be applicable a year later? I mean the examination should be made at the time he is before the court, should it not?

Mr. SANDERS. The examination, too, is to be made after conviction and before he has been assigned to an institution.

Mr. HOFFMANN. But I think the question is—the prisoner who was convicted 2 years ago for an offense for conviction of which, if he were convicted now, he would be eligible under title II. Upon passage of the bill, he is no longer an addict. He has been in prison for 2 years. We hope he is not still an addict.

Now, how under this legislation do we get some retroactive consideration for this fellow?

Mr. SANDERS. Well, if he is no longer an addict, he is not eligible under it, Mr. Hoffmann.

Mr. HOFFMANN. So that the intent of the statute is not to avail this remedy for people who are convicted 1 or 2 years ago.

Mr. SANDERS. It is not.

Mr. GRIDER. Are there not prisoners who are still addicted?

Mr. SANDERS. It gets to be something of a medical question as to whether they are addicted, I think. Their physical addiction is eliminated, as I understand the medical usage, within a relatively short period of time and then we focus on the aftermath phase of the problem.

Mr. ALEXANDER. On the institutional or correctional treatment.

Mr. GRIDER. You do not have any prisoners in Federal prison who are still able to get the stuff after they are in prison?

Mr. ASHMORE. We hope not.

Mr. ALEXANDER. We are dedicated to seeing that they do not. And it is on very, very rare occasion that a wife will try to smuggle something in, or a visitor. This has happened on rare occasions. But I think I can testify with assurance and confidence that we do not have practicing addicts in our institutions.

Mr. MCCLORY. Mr. Chairman, could I ask a question along the same line as this question that is going on. What is your view with regard to the user who is not a criminal? Do you have an opinion as to whether or not they should be subjected to the same or similar treatment as we have here? On the basis that the user is a potential criminal because he is apt to do these things that would cause him to commit crimes and thereby apt to get into this category covered by this bill?

Mr. ALEXANDER. If I understand your question correctly, you are asking whether there should be a provision for a voluntary commitment for a person not charged with an offense?

Mr. MCCLORY. Well, that, but I am thinking, too, that the person who is making the offense to be a user, because the user is a potential criminal. After all, he has received his narcotics through some illicit manner.

Mr. ASHMORE. Mere use of it is not a crime.

Mr. SANDERS. If we have no charge against him, we cannot do anything under the bill.

Mr. MCCLORY. No; but what is your opinion as to that category?

Mr. ALEXANDER. So that there would be a mandatory commitment rather than a voluntary commitment of the addict not charged with offenses?

Mr. MCCLORY. Yes, to submit to medical treatment, civil treatment.

Mr. ALEXANDER. Well, first of all, there exist provisions for voluntary commitment. I cannot give you the numbers right now, but there are voluntary commitments regularly being treated at Lexington and Forth Worth hospitals.

One of the problems, as I understand it, and I am afraid I am not competent to testify on this, is the problem of voluntary patients who then suddenly decide after a week or two that they want to leave. But I am really not competent to testify.

Mr. HUTCHINSON. Mr. Chairman, in order to mandatorily reach such an individual, it would seem as though the Federal statute would have to make use a crime.

Mr. ASHMORE. That is right. That is the only way you can do it. And that has not proved practical, has it?

Mr. SANDERS. No, sir; it has not. I would not think it would be effective, at least as we know the present situation, to enlarge the scope of the statute in that manner. There must be a way of getting them

before the court. This can either be by virtue of present statutory violations or by adding other statutes to the code. We do not think the latter would be practical.

Mr. HUTCHINSON. I have a question along another line that perhaps has been touched on in other testimony. I do not know. But it is this. Has any assessment or study been made as to how much this program will cost?

For instance, if this bill, H.R. 9167 were enacted, what would it cost to administer it?

Mr. SANDERS. We are not asking for increased appropriations in connection with this bill. Now, as to what it would cost, with respect to the Surgeon General's operations he can testify on this with more expertise than I could.

Obviously, it is going to take some money to contract, if you are going to contract with State agencies or private authorities, for the intensive supervisory aftercare which is called for. My understanding of the testimony which the Surgeon General and those in HEW and NIMH gave was that there were presently programs which could make this money available. I do not know the amounts of money which would additionally have to be appropriated under those programs.

Mr. HUTCHINSON. Can you say the Federal Bureau of Prisons would require no more money than it is now receiving if it were called upon to administer the title II of H.R. 9167?

Mr. SANDERS. The Federal Bureau of Prisons Director is here. I think he could address himself to the question.

Mr. ALEXANDER. Those who would be committed to us under this bill are presently being committed to us. And we have appropriations available. At this time, I foresee no additional appropriation is being required to handle these same offenders we are handling now under our present appropriations.

Now, we will be increasing, as I testified earlier, our employment placement and guidance people. This program is financed by the Federal Prison Industries, and is an extension of vocational training. I see nothing in this that will increase by any great substantial amounts the appropriations that we will need in order to operate over and beyond what we are presently doing.

There will be a shifting, a redistribution of our resources, but I do not see that this is going to involve any real increase in appropriations to administer this treatment of addicts over and beyond that which we now have.

Mr. HUTCHINSON. I have one other question, Mr. Chairman. I understand that the States of New York and California especially, have set up programs along the lines which are contemplated by H.R. 9167. Is it the thought of the Justice Department that if H.R. 9167 were enacted and this program was set up countrywide so far as the Federal Government was concerned, that the States would be expected or we would hope that each State would emulate this program and set up a similar program at the State level, not only just California and New York, but the other 48 of them?

Mr. ALEXANDER. I would anticipate wherever a State has a problem of addicts, and there are some States who have very, very little, that we would be able to work in close coordination and jointly with them.

Certainly, we would not expect California to change their program or New York, which has somewhat different program, to change theirs. But rather through demonstration and with those cities and those States who have a problem that we could work coordinately, even as we do in some other elements of our programs.

I would hope that as the program develops, we would maintain close liaison and cooperation with States, because we are never going to solve this by isolated programs, either by the Federal Government in some places, or——

Mr. HUTCHINSON. Well, let us put it this way. Suppose in a State where there are not really very many narcotic addicts and they do not have any problem and consequently their State government has never given any consideration to setting up anything akin to civil commitment and all of this that is contemplated here. But an individual is charged in that State under violtaion, let us say, under the State law. And he immediately, or along the course of his criminal process, through his lawyer says, "Well, if we could get this man changed under the Federal law, he could get the benefit of this program which the State will not give him."

In that case, do you contemplate that the Federal Government would be prosecuting practically all narcotic addicts?

Mr. ALEXANDER. I should not think so.

Mr. HUTCHINSON. In those States?

Mr. ALEXANDER. In a State where this situation would occur as you have suggested, there are a number of ways in which we can work with them. If they only have an occasional, isolated narcotic addict, and this is true in some States, there are provisions existing now in Federal law in which we can accept those State prisoners and the State pays our per capita cost.

We board numbers of State prisoners for different reasons. And the same could apply to treatment and handling of addicts.

Mr. HUTCHINSON. Thank you. That is all.

Mr. MCCLORY. Mr. Alexander, do you have a statement as to how many of the prisoners there would be? How many people convicted now who would be charged now under a Federal law that would come under this category?

Mr. ALEXANDER. Over the past 5 years, in the Federal prison population, we have had a population of 1,200 to 1,500 with a history of addiction. About half of those have been charged with narcotic violations, and about half with other offenses, usually offenses which flowed from addiction to support the habit. Now that is the best figure, Congressman, that I can give you at the moment.

Mr. MCCLORY. Now, wouldn't it be necessary to have new and additional facilities in addition to the facilities that you have now, which would require an appropriation?

Mr. ALEXANDER. I don't think there would be. I see no reason why this bill would increase the number of persons with a history of addiction being committed.

Mr. MCCLORY. Well, you wouldn't want to confine these cases, though, in the same institution where you have the criminals, would you?

Mr. ALEXANDER. Oh, yes.

Mr. MCCLORY. You would put them in the Federal prison but in a different part of the Federal prison?

Mr. ALEXANDER. No, we have them now in our regular institutions, because the principal problem the addict presents is not just the addiction per se, it is the fact that he has the same kind of characteristics that the ordinary delinquent criminals would have.

Mr. MCCLORY. Would they eat in the same place?

Mr. ALEXANDER. Yes. Work in the same place.

Mr. MCCLORY. With the other inmates?

Mr. ALEXANDER. Yes.

Mr. MCCLORY. Do you not think——

Mr. ALEXANDER. Excuse me. I am speaking of those committed under criminal commitment, not those under civil commitment.

Mr. ASHMORE. You have no civil commitments?

Mr. ALEXANDER. No, sir; they would not come to us.

Mr. MCCLORY. I am talking about if we enact this bill, if this becomes law, are you going to house those who were civilly committed in the same institution where you have the criminals?

Mr. ALEXANDER. No, sir. I am sorry; I misunderstood you.

Mr. MCCLORY. Are you not going to need a new facility for them? A new institution?

Mr. ALEXANDER. The Public Health Service now has hospitals at Lexington and Fort Worth, and this would be the responsibility of the Public Health Service.

Mr. MCCLORY. And those are the places you would expect them to be institutionalized, then, at the same place where you have the voluntary cases?

Mr. ALEXANDER. Those who are civilly committed.

Mr. MCCLORY. Well, you have voluntary commitments at Lexington, do you not?

Mr. ALEXANDER. That is right.

Mr. MCCLORY. And you would have these who——

Mr. ALEXANDER. And we also have at Lexington and Fort Worth criminally sentenced offenders also. But under the provisions of this the Bureau of Prisons will be responsible for the criminally committed. Public Health Service will be responsible for those civilly committed. Now, in the development of programs including community-based programs, and the use of mental hygiene clinics and services in communities, the Public Health Service would use a wide variety of services.

Mr. MCCLORY. That would relate more to the aftercare program would it not—the community service? You would not have the earlier treatment take place in the community—the clinic or the community?

Mr. ALEXANDER. I think this is a question of which the Public Health Service will have to give you the specific information as to planning on it.

Mr. MCCLORY. Yes, I agree with that, but at the same time, does that not bear upon the question as to whether or not additional facilities will be required? I mean if they are not going to use the community facilities for the initial civil commitments, then it is not a fact that additional facilities will be required, or are you stating that Lexington already has adequate facilities to take care of the civil commitment cases?

Mr. ALEXANDER. Well, I simply cannot testify as to what Public Health Service plans are, but Public Health Service, in addition to

Lexington and the Fort Worth hospitals, with capacities of upwards of a thousand each, also has U.S. Public Health Service hospitals and services throughout the country, and I simply cannot testify as to Public Health Service plans in handling the civilly committed.

Mr. McCLORY. Do you have any familiarity with the requirement for additional doctors, therapists, attendants, and security officers and all the rest of the personnel that would be required to administer such a program as this for the 600 or more cases which might presently fall under this law if we had it in effect?

Mr. ALEXANDER. You mean the criminally or the civilly committed?

Mr. McCLORY. Well, as I understand, you said that you have from 1,200 to 1,500 in the Federal prisons now, and of that number about half would be eligible under the civil commitment provisions of this bill, if we had the bill now.

Mr. ALEXANDER. No, sir; I am sorry if I conveyed that impression. I said about half of them are committed for violation of narcotics laws.

Mr. McCLORY. Yes.

Mr. ALEXANDER. And over half for violation of other laws. I did not intend to make any estimate as to the number presently committed under violation of criminal laws who might be committed under civil commitment. I did not intend to convey that impression.

Mr. McCLORY. Are you not giving us any estimate of that number? How many people we are accommodating through this legislation?

Mr. SHATTUCK. Might I interject at this point that previous testimony indicated that perhaps the eligible group would range from 800 to 1,000, and it just happens the figures you have given us, Mr. Alexander, would lead us to this conclusion. Just as the Congressman has stated, approximately half might fall in this category.

Mr. McCLORY. We have testimony now that we do not need any additional appropriations because we train Public Health and the Department of Justice. We have got all the appropriations we need and had not envisaged additional appropriations.

Now if we are taking care of 800 to 1,000 individuals under a new program, it seems to me that we do need some additional appropriations, and we ought to know what they are and what they are going to do, and where we are going with this program at this time.

Let me say this, we have had the witnesses here from New York, and there seems to be very little effectiveness of a very good law in New York because they do not have the appropriations to provide either the personnel or the facilities. They do not even have a director of the program at the present time because apparently they cannot find the right person to administer a program similar to the one that is being recommended to this committee.

Mr. ALEXANDER. My position is, Congressman, that on these who are presently committed, under criminal commitments, we already have appropriations; we already have them in our institutions. We already have the medical and psychiatric and supportive personnel. We certainly already have the custodial provisions and personnel. There is foreseen no really substantial increase in the requests for appropriations to administer this program because we can substantially carry it out with our existing personnel and already have resources.

Mr. ASHMORE. If you just divide the group that you now have.

Mr. ALEXANDER. Then, too, if there be indeed an assumption that the majority of those presently committed for nonnarcotic offenses, that is of the addict group, that the large majority of these would be committed civilly, I think that would be an erroneous assumption.

Mr. SHATTUCK. I do not think that was an assumption, sir. We were talking about the potential people in this group who might be eligible for civil commitment in order to give members the bases of judgment as to just what the possible effect of the legislation would be. I do not think any projection was made as to who would actually be selected.

Mr. MCCLORY. These 800 or 1,000 people who would fall under this legislation would not be secured in a Federal penitentiary, would they?

Mr. ASHMORE. Civilly committed do not go to the penitentiary; they go to the Surgeon General.

Mr. MCCLORY. Nor would they be in any part of any Federal penitentiary facility.

Mr. ALEXANDER. You see presently, numbers of our criminally committed offenders are treated at Lexington and Fort Worth. Now, some of this group would become our prime responsibility. It would not mean that we could not contract with Public Health to handle certain offenders for whom this might be indicated, but there would be some shifting of population between those now at Lexington or Fort Worth to our facilities that are now in those institutions.

Mr. MCCLORY. So it is your opinion that whether the facilities are Public Health Service or the Department of Justice, the Bureau of Prisons facilities would require no additional physical facilities.

Mr. ALEXANDER. That is correct, so far as the Bureau of Prisons facility is for handling the criminally committed is concerned.

Mr. MCCLORY. And you do not know with regard to the civilly committed?

Mr. ALEXANDER. This is a Public Health responsibility and I cannot testify as to the impact this will have.

Mr. MCCLORY. You are really giving no opinion as to whether or not any additional appropriations are needed to administer this insofar as——

Mr. ALEXANDER. To administer the civilly committed.

Mr. MCCLORY. You have no opinion on that?

Mr. SANDERS. I might add one thing as I understood some of the other testimony or statements, the present facilities at Lexington and Fort Worth would be sufficient to care for the civilly committed. We, of course, just do not know what the ratio is going to be between the civilly committed and the criminally committed, because we have not dealt with the idea of civil commitment heretofore. I do not think any of us would be in a position to say that the Surgeon General would never need additional facilities to administer this act. I do not think, as I understood their testimony or the statements in my discussion with them, that they contemplate additional facilities at this point.

Mr. MCCLORY. Do you have an opinion as to whether or not persons confined under this legislation would have to be segregated or separated from those who are otherwise committed or who are being treated at a facility such as Lexington?

Mr. SANDERS. They are not now, for the most part.

Mr. MCCLORY. Would they be under this legislation, or should they be since we are talking about the rehabilitation of a person that has some connection with a criminal offense?

Mr. SANDERS. I see no reason why there should be an absolute separation between them. First of all, they have been charged with a criminal offense. They have presumably been delinquent or criminal, but in lieu of a criminal commitment will be civilly committed. The characteristics of these individuals and voluntary patients are not too divergent. It is not mixing oil and water at all. It is people who, as developed here, came out of areas of deprivation, who need all of these resources that can come through education and training, and to say just because they were civilly committed or criminally committed must always be absolutely isolated, seems to me to be—well, impossible.

Mr. MCCLORY. Do you know whether or not the Crime Investigation Committee appointed by the President is investigating and preparing to report on this area that we are investigating here?

Mr. SANDERS. They are looking into some of the problems of addiction and narcotics. To what extent I do not know. As a matter of fact, they are meeting today and just what some of their conclusions will be, or whether they have even reached any, I do not know.

Mr. MCCLORY. That is all that I have. Thank you.

Mr. HOFFMANN. I would like to ask one or two brief questions. Mr. Alexander, to what extent under title II does the present legislation help you with the addict who is convicted for a nonnarcotic crime? Let me recap a minute, because I would like to get some specifics on these figures. You estimate that you have got 1,200 to 1,500 Federal convictions, "narcotics histories" as you phrased it?

Mr. ALEXANDER. That is right.

Mr. HOFFMANN. You do not know how many of those are going to be addicts qualified under the law at the time of their conviction?

Mr. ALEXANDER. No; I could not give you a figure. First of all, this would involve a pretty complex kind of a study. For example, four different groups who are ineligible, for example, for civil——

Mr. HOFFMANN. Not to cut you off, sir; but of these people who have histories at the time of their conviction, we have no way now of knowing how many are going to qualify as addicts under this law?

Mr. ALEXANDER. That is correct.

Mr. HOFFMANN. All right, now assuming that say a thousand could qualify, you would estimate the split between the narcotic and nonnarcotic offenders to be about 50–50.

Mr. SANDERS. That is right; that is what the figures show.

Mr. ALEXANDER. That is what it is at present.

Mr. HOFFMANN. With the nonnarcotic offender, do you, as the U.S. correctional officer, have any trouble in the flexibility of the sentences that are meted out for this class of criminal?

Mr. ALEXANDER. For the nonnarcotic?

Mr. HOFFMANN. For the nonnarcotic offender. Your hypothesis was the fellow who steals the Federal check in order to feed his habit——

Mr. ALEXANDER. The person charged with offenses other than narcotic violation.

Mr. HOFFMANN. Yes, sir.

Mr. ALEXANDER. We have no problem so far as provisions of sentence. They are eligible for parole. They are eligible for the Youth Correction Act, for all of these provisions that are included in this bill for the narcotic offender.

Mr. HOFFMANN. But the penalty structure is not as inflexible in these cases as it is with the narcotic offender. Was that not the thrust of your testimony?

Mr. ALEXANDER. That is correct.

Mr. HOFFMANN. With the narcotic offenders, with those who have violated the narcotics laws, they are primarily the ones who are going to be helped by title II?

Mr. ALEXANDER. Yes; to the extent that parole eligibility will become available to marihuana offenders and to the extent that the Youth Correction Act can be applied to those offenders under 26.

Mr. HOFFMANN. But will not this indeterminate sentencing procedure be available to narcotic offenders as well, under title II?

Mr. SANDERS. If an offender is sentenced under title II, as a narcotic addict, his sentence will relate to the sentence for which he is otherwise eligible. This means the maximum cannot exceed—take the case of an offense carrying a 10- or 15-year penalty, the penalty for the offense for which he was charged and convicted.

Mr. HOFFMANN. I understand that, but if a man is convicted under 21 U.S.C. 174 for a heroin violation, and there is a mandatory minimum involved under present law, would that man qualify under title II for release after 6 months if the parole board thinks well of it?

Mr. SANDERS. He would qualify if he has been sentenced under title II.

Mr. SHATTUCK. May I direct your attention to subsection 2 of paragraph (g), and request that you also comment with reference to the point of whether the sale was to support the habit, in effect?

Mr. HOFFMANN. That is to be considered in this context, is it not? This was under the so-called import statute.

Mr. SANDERS. Well, the import statute has to do with——

Mr. HOFFMANN. The classic case I am talking about.

Mr. SANDERS. Subsection 2 disqualifies those who are selling unless it is to support their habit.

Mr. HOFFMANN. That is right.

Mr. SANDERS. Right.

Mr. HOFFMANN. All right, now let me ask Mr. Alexander this question. When you get the addicted narcotic offender, do you now classify him for treatment purposes as a pusher or just an addict? Do you make that investigation?

Mr. ALEXANDER. Well, we make that determination but this has, if I understand your question—we do not apply different treatments based per se on whether the offender is a pusher or an addict. If you mean we set them up and classify, we have categories that we put the pushers off on this—it depends on the individual, the individual problems, diagnosis and/or resources available to us.

Mr. HOFFMANN. I have some questions on civil commitment. I do not know whether you want to get into that, Mr. Chairman.

Mr. ASHMORE. Go ahead.

Mr. HOFFMANN. Mr. Alexander, when you get the addict offender of any kind, could you give the committee some idea of the extent to which there is a medical as opposed to a psychological problem?

Mr. ALEXANDER. Well, the medical problem is primarily one that is met and handled very early, immediately following commitment. Obviously the psychiatric-psychological implications are much more extensive, much more basic, and our psychiatrist and psychologist and the ancillary personnel who support them, any of these people are involved in group therapy over a period of months or even years, if they are there. This is one of the things that we are suggesting is needed, so imperatively, during the immediate release period as well.

Mr. HOFFMANN. Does he then represent a greater problem to you after the physical addiction is cured than the average inmate?

Take two people. They are both convicted for stealing Government checks. One is an addict; one is not an addict. After you get the addicted convict through withdrawal and get him off the drugs, is he a more acute problem to you than the fellow who just stole that Government check because he could not get work, was not adequately trained, came from a bad background, and was generally not able to fit constructively into society?

Mr. ALEXANDER. No; I would not agree that he presents a more severe problem. Usually the problems which I would call the problems of correctional treatment in the areas of education or vocational training, of group therapy, all of these are almost precisely the same. Once the addiction part, his dependency on drugs has been taken care of, he presents almost the same kind of a complex problem that the nonaddict does. On release, then, the problem of the addict returning to the kind of an environment where addiction is most likely to recur, then becomes a problem, too, but it is also true with the kid, the youthful offender who has run around with a group stealing cars all the time, who is going back into that same kind of community. My view is that the causative factors underlying addiction are almost the same kind of causation that leads to stealing cars or the other kinds of delinquent behavior that these young delinquents and criminals engage in, and that there is really not so much difference in the correctional process between the average addict and the average automobile thief.

Initially you have this problem of the addiction and at release you have the problem of the environment to which they are returning, and the kind of guidance, support, and control that is given them.

Mr. HOFFMANN. But you would think that the problem created by the addict criminal is such as to justify legislation that pretty much presumes any criminal act committed by an addict is a product of that addiction?

Mr. ALEXANDER. I am afraid that I will have to hear that question again.

Mr. HOFFMANN. There is no requirement in title I that for a nonnarcotic offense there be any casual relationship established between the crime and the offender's addiction. Therefore, the connection must be presumed to justify this preferred treatment. There must be

something in the addiction that warrants making this step in his favor, where we do not make it in favor of another criminal.

Mr. ALEXANDER. Well, I could not agree that this is preferred treatment. Actually what this bill does so far as the addict offender, committed for a narcotic violation, is concerned, is to make available the same kinds of programs and resources including the Youth Corrections Act with its flexibility and parole for marihuana cases, to give them the same kind of treatment that is now made available to the nonaddict offender, or for the addict charged with an offense other than narcotics.

Mr. HOFFMANN. But is that not a more enlightened treatment for that man?

Mr. ALEXANDER. I think so; yes. But I do not call it preferential treatment. I say that it makes available the same kind of treatment resources.

Mr. HOFFMANN. Now I had a question of Mr. Sanders with regard to the preconviction civil commitment. There has been testimony that the chief advantage of having this procedure in the law is to get the addict off the street as quickly as possible. Several witnesses have stressed this as the real justification for it. I wonder if you would outline the mechanics of how this process would work, with regard to the necessity for hearings at various steps, and on the possibility of pulling the addict-arrestee right in off the street for immediate commitment?

Mr. SANDERS. Hearings in connection with whether he is eligible for treatment under the civil commitment title?

Mr. HOFFMANN. Whether he is eligible, if he has 5 days to decide whether he wants——

Mr. SANDERS. Right after he is first advised.

Mr. HOFFMANN. What if he is not advised? And his lawyer decides he would like him to be advised?

Mr. SANDERS. The 5 days, in our view of the wording of the bill, runs from the time that he was first advised. I think the language you are talking about says at the first appearance he may be advised and has 5 days thereafter to elect an examination which may result in civil commitment. Now if it is the committee's view that this is not clear enough, we have no particular pride of authorship about making it clear. We do think it is important, however, that there be a fairly brief time limit, be it 5 days, 6 days, or 7 days, in which the man must make his election after he is advised that he can do so. The mechanics of it would be, as I envision them, the man is brought into court, he may be brought into court after indictment in order to be arraigned, and enter his plea. He might be brought in before indictment, because as you know, people in many instances do plead to an information in lieu of indictment. They say, "I want to come in. I want to appear just as soon as possible." Presumably at that time he would be advised. If he were not advised at that time, and I cannot imagine why he would not be unless the court did not have information indicating that it ought to give such advice. When the court gave such advice, the 5-day limitation would start running. He must make his decision within 5 days.

Then he would be committed for examination, unless his record shows on its face that he is ineligible either because of a crime of violence, because of prior felony convictions, or because he is under another felony charge or has not completed serving time on probation with another authority, and so on.

Mr. HOFFMANN. Can the U.S. commissioner make the intial determination?

Mr. SANDERS. He could under 9051, but not under the administration bill. We think the determination should rest with the U.S. district judge.

Mr. HOFFMANN. In the District of Columbia, a man is normally arraigned before the commissioner.

Mr. SANDERS. No, sir; he is never arraigned before a commissioner.

Mr. HOFFMANN. Correction. He is brought in after his arrest.

Mr. SANDERS. Right.

Mr. HOFFMANN. He is arrested on a warrant and he is acquainted with his rights to counsel, and so forth.

Mr. SANDERS. Yes, sir; that is right.

Mr. HOFFMANN. He can get a preliminary hearing if he would like, the bond is posted, and he is either committed or goes out on bail.

Mr. SANDERS. That is correct.

Mr. HOFFMANN. Can you tell me the average time in the District of Columbia between that stage and the time the indictment is returned on him?

Mr. SANDERS. I think the figures are a matter of record. I have seen them somewhere in these pages. I would hazard a guess it is 30 to 60 days. It may be more in some in instances and in some instances it is less. The point I am making, though, is that he could come in before indictment and enter his plea and we believe he would—this often happens in the District of Columbia and all the other 91 districts. It might be a matter of 2 or 3 days after his hearing before the commissioner. He can be brought in.

Mr. HOFFMANN. So that this law has not really done anything as far as the fellow who would not ordinarily come in. If you are depending on the fellow that would come in anyway, under the present law, to take advantage of this, how does this law help us with the fellow that is amenable to correction, that we want to take off the street, but who is not going to come in within this 30 to 60 days? Do you see a problem here?

Mr. SANDERS. He will be out while he is awaiting indictment, that is true——

Mr. ASHMORE. True in every case.

Mr. SANDERS. But there is no way in which we want to tamper with the man's right to an indictment if he wants to be indicted. Now if you think of the other side of the coin, let us consider the commissioner making the determination. This would get the addict off the street right then and there. The problem about that, I think, goes to the commissioner system and the qualifications of the commissioners and their procedures. Our experience with these matters would indicate that this is the sort of thing that should be reserved for the U.S. district judge, rather than a commissioner. Now a judge could act as a commissioner if he so chose. I do not think that he does in the District of Columbia. He does not in most metropolitan areas, but in many districts he does.

Mr. HOFFMANN. So in those districts we would have the right, immediately after arrest, to take the monkey off this fellow's back: he must either have elected or not elected?

Mr. SANDERS. I do not think the application is going to be quite this difficult.

Mr. HOFFMANN. Do you not see an advantage in giving either the commissioner the power to do it or getting a mechanism whereby this man is in the first 5 days made to elect, so that we get him off the street?

Mr. SANDERS. I see the advantage of speed if the commissioner does it. However, it is offset by a disadvantage, the commissioner's qualification, the informality of the procedures, at the commissioner's hearing.

Mr. HOFFMANN. Where is the enhanced speed under this statute, if we wait 30 to 60 days?

Mr. SANDERS. The enhanced speed, for one thing, comes from the time of arraignment to the time of trial as quite a difference. In many districts that amounts to several months. The normal procedure is—I can get you figures for any particular district you may want, and they vary—you indict a man, you bring him into court very quickly to plead, and you set a trial date for him. As you know, and it may be 2 or 3 weeks or if the docket is heavy at the time, it may be 8 or 9 months. That we cut out under this bill. No question about that.

Mr. HOFFMANN. You stated if he wants to plead guilty or enter a plea, he can do so at arraignment?

Mr. SANDERS. That is right.

Mr. HOFFMANN. Suppose we took a device like modifying the present policy of the Department of Justice on nolo contendere please, and have a postconviction remedy available as it is in H.R. 9167 after a nolo plea. Why would we need preconviction commitment? What would we lose out of the civil commitment by doing it with a nolo plea?

Mr. SANDERS. Well, I think in the first place, so far as it is a nolo plea situation, we are getting into another broad area. I do not think it really relates here. If what you are proposing is to have him just plead nolo and make this a special plea for narcotics addiction or those who want to utilize this law. It really has not occurred to me. But we do not look with favor historically on pleas of nolo. It is recognized as the gentleman's plea of guilty. I think that is one way it has been put. The man who comes in after indictment or arraignment and pleads guilty, commit him right then and there under title II, or we could civilly could be committed before he enters his plea. Same difference. But for the man who comes in after indictment to enter his plea, and is undecided whether he wants to plead guilty, he pleads not guilty and a trial date set. Obviously there is some advantage in speed in connection with him. Also, there are somewhat more advantages to this than just the element of speed when we are talking about civil commitment. There is this advantage—while a man who is civilly committed has an arrest on his record and may or may not have an indictment, depending on what course his proceeding takes, may not have a conviction on his record. I understand that this means a good deal when people are seeking rehabilitation. I can see how it well might. He does not have a conviction because if he goes through the course of treatment successfully, the charge is dismissed on the urgeon General's certificate to the court. He is then unconditionally leased and there is no conviction on his record.

Mr. HOFFMANN. Let me stop you right there. Would you comment on the advantages of doing it this way and the simple expunging procedure after my nolo plea, if you will, so that the record is expunged as they do under the Youth Corrections Act?

Mr. SANDERS. I will be glad to comment on it. I think when you talk about expunging, you do not really expunge anything. "We are going to expunge the record." Does not mean we are going to burn up the record. It just means we have a conviction on the record and somebody else says that conviction is expunged. Still the conviction was there. Any time anyone went into it, it would be known that the man was convicted and thereafter the conviction was expunged.

It seems to me an unnecessary refinement. We think it best to do it this way and avoid the afterhazard, so to speak, of a conviction on the record. I know the expunging process is viewed with favor by some. I do not think it is absolutely effective. I think the civil commitment route is much preferable when both reach the same end.

Mr. HOFFMANN. Maybe we could bring Mr. Alexander in on this.

Mr. SANDERS. I think he is enjoying his rest.

Mr. HOFFMANN. Do you think there is a difference, then, in rehabilitating a man, between having a man go out with a criminal record which he can establish was a product of his addiction and having him go out a committed addict who was brought to the attention of the committing authorities by arrest for the commission of a crime, which as you point, may or may not lead to indictment?

Mr. SANDERS. I want Mr. Alexander to be brought in but I would say this, it is probably going to be a somewhat subjective determination by all of us. That would be my judgment. It would be upon the evaluator and would depend on the purpose of the evaluation, whether it is a potential employee or whether it involves the Baum law. Let us say in New York State I do know expunging the record really just means nothing. The Youth Corrections Act authorized the Board of Parole, after a period of supervision, to enter an order expunging the record. We cannot state that it means a single thing. It is still on the FBI records as is his record of arrest, and when a man goes out to look for employment or enlists in the Army, he has to list that he was convicted of this charge, but the record was expunged. So what does this mean—"expunge"?

Mr. HOFFMANN. This is under the Youth Correction Act?

Mr. ALEXANDER. Under the Youth Corrections Act the Parole Board may expunge the record and none of us can figure out what is expunged and to what end and purpose?

Mr. HOFFMANN. Mr. Sanders, did you have anything more on the list of advantages of civil commitment that you wanted to get into?

Mr. SANDERS. Not at this point.

Mr. ASHMORE. All right, gentlemen, that will conclude our hearing today. We will take a recess until further call of the chairman. We may meet again on Wednesday or Thursday, which will be determined, and I might add there will be no meeting of the Claims Committee for consideration of claims until next week.

(Whereupon, at 12:25 a.m., the hearing in the above-entitled matter was adjourned sine die.)

HEARING ON BILLS PROVIDING FOR CIVIL COMMITMENT AND TREATMENT OF NARCOTIC ADDICTS

WEDNESDAY, JANUARY 19, 1966

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
SUBCOMMITTEE No. 2,
Washington, D.C.

The subcommittee reconvened at 10 a.m., in room 2226, Rayburn Building, Hon. Robert T. Ashmore presiding.

Present: Representatives Robert T. Ashmore (presiding), Jacob H. Gilbert, George F. Senner, Jr., William L. Hungate, George W. Grider, Edward Hutchinson, and Robert McClory.

Also present: William P. Shattuck, counsel for Subcommittee No. 2; and Martin R. Hoffmann, minority counsel.

Mr. ASHMORE. Gentlemen, I think we will open our hearing. We have some other members on the way, but a lot of them are apparently delayed this morning. We will resume our hearings on several bills for civil commitment and treatment of narcotic addicts. We will talk mostly about H.R. 9167, commonly called the addicts bill introduced by Mr. Celler, chairman of our full committee, and also another bill introduced by Mr. Celler, H.R. 9051.

This will possibly be the last hearing, although something may come up that will make it advisable to call some other people as witnesses. But today we have two important people with us, two people who I am sure can give us a good bit of help and information. The Honorable David C. Acheson, Special Assistant to the Secretary, Department of Treasury, and Hon. Henry L. Giordano, Commissioner, Bureau of Narcotics, also of the Treasury Department.

Mr. Acheson, I believe, is now in a new job and this is probably your first appearance as a witness since you have been in this position; is that right?

Mr. ACHESON. That is correct, sir.

Mr. ASHMORE. We welcome you here and we are delighted to have you as a witness.

Mr. Acheson, we will be glad to hear from you at this time.

STATEMENT OF HON. DAVID C. ACHESON, SPECIAL ASSISTANT TO THE SECRETARY, DEPARTMENT OF TREASURY; ACCOMPANIED BY COMMISSIONER HENRY L. GIORDANO, BUREAU OF NARCOTICS, DEPARTMENT OF TREASURY

Mr. ACHESON. Mr. Chairman, Commissioner Giordano and I understood that in the course of the previous hearings some questions have

arisen on these bills, and that this hearing was called primarily to consider those questions.

Mr. ASHMORE. Yes.

Mr. ACHESON. We have no prepared statements to make. The Treasury did submit a statement through Mr. Hendrick last June or July.

Mr. ASHMORE. I remember when Mr. Hendrick was here.

Mr. ACHESON. The position stated there, of course, is one we adhere to.

I might add to it only to say that we think this bill H.R. 9167 does some important things that need doing. Perhaps the most important is to provide a framework for treatment of narcotic addicts beyond the rather limited treatment of hospitalization which is the only form now available through Government channels, and that it seems to contain reasonably effective safeguards for screening out the racketeers and the traffickers from the people you want to help.

Beyond that I don't have any statement to make, unless Commissioner Giordano has something to add to that.

Mr. GIORDANO. No, I haven't, Mr. Chairman. I support what Mr. Acheson has said and I am prepared to answer any questions that the committee would put forth.

Mr. ASHMORE. Are both of you gentlemen favorable to the civil commitment idea as set forth in both of the bills?

Mr. ACHESON. Yes, Mr. Chairman.

Mr. ASHMORE. Which do you think has been most successful, the New York plan or the California plan?

Mr. ACHESON. My own impression is that the California plan has been relatively effective, though the experience is perhaps too short to be definitive on that, and that the New York plan has been markedly ineffective. I think Commissioner Giordano can expand on the reasons for that from his own experience.

Mr. ASHMORE. Yes. We would like to know what the shortcomings are there.

Mr. GIORDANO. The shortcomings in the New York plan, which we did have some part in drafting in cooperation with the State of New York, is the fact that in their narcotic laws they provide for a quantitative difference, one-eighth ounce of possession. If it is below an eighth of an ounce of heroin, it is considered a person had it only for his own use. If above an eighth of an ounce, it is considered possession with intent to sell.

Now the under eighth ounce is the misdemeanor——

Mr. ASHMORE. Is that the only distinction they make between one who has it for his own use and one who is a pusher?

Mr. GIORDANO. Right. What they do is make a felony out of a quantity over one-eighth and only a misdemeanor for the quantity below an eighth of an ounce.

What has happened in New York is that out of the cases that have been brought by the police into court, 60 percent of those cases were reduced in order to clear the calendar from felonies to misdemeanors. As a result, this nullifies the effect of the Metcalf-Volker Act, which was the commitment act, because the individual then would get a sentence anywhere from 30 to 60 to 90 days. So rather than take the 3-year commitment they went on the misdemeanor plea for 30 days. So

actually it has been sort of a merry-go-round situation in New York. An addict is arrested, they permit him to accept a reduced plea, he gets 30 to 60 days and he is back out on the street and then back in jail again.

Mr. ASHMORE. They are expediting the business of the court and destroying the purpose of the bill, aren't they?

Mr. GIORDANO. Definitely.

Mr. ASHMORE. What about the after care, treatment after they are released? We have found throughout these hearings that this is a problem that gives most worry and trouble and difficulty to all of us, I think, and the same has probably been true to the people who have had these problems to handle in actual practice.

Mr. GIORDANO. Well, Mr. Chairman, in referring to the California plan we find that they appear to be having success, as Mr. Acheson mentioned it is a little early to make a full determination, but from what we can gather this appears to be approaching it in the right direction. And they have a rather substantial aftercare program out there in California.

New York intends to have a similar aftercare program, but apparently, as far as we can gather, the facilities that are available are not sufficient and here again I think is the question of money becoming involved, in setting up the aftercare program. So their program, unfortunately, while I think the law itself is adequate, we did recommend that they provide a compulsory commitment feature. I don't mean provide it, only after the addict has committed a criminal offense—they should utilize it more, a compulsory commitment feature where the individual was not involved in a violation.

They have this in the bill, that certain persons can bring an individual before a magistrate and have him committed to an institution for treatment and for aftercare. They haven't utilized that feature though.

Mr. ASHMORE. That is the New York law?

Mr. GIORDANO. New York and California also.

Mr. HOFFMANN. Was the California enactment the result of the *Robinson* case, do you recall?

Mr. GIORDANO. No, it is not geared to the *Robinson* case. The California enactment is the result of a number of hearings in California, considerable agitation in California, because of the situation in California, particularly in Los Angeles.

Several committees were formed, Governor Brown had a committee that researched the program. I wouldn't say that it was entirely the result of the *Robinson* case.

Mr. GRIDER. Mr. Chairman.

Mr. ASHMORE. Mr. Grider.

Mr. GRIDER. I take it the experience with those addicts who have had their charge reduced, so they are only liable for a short jail sentence, show little willingness to voluntarily submit to commitment and treatment? Is that your experience in New York?

Mr. GIORDANO. That is my experience all over the country, that in the majority of cases there has to be some form of compulsion and some pressure on the individual to make him select treatment rather than something else.

As I indicated earlier, we felt in New York, providing they had the facilities, that they could use the compulsory commitment on an individual, even though he wasn't involved in a criminal act.

Many of the States at the present time have laws that would provide this. However, unfortunately they don't utilize those laws. Some of them are laws that are geared to the inebriate where it also says "or uses drugs," where they can commit them, but unforunately they are not utilizing those laws. But there must be compulsion, I feel.

Mr. HUTCHINSON. Mr. Chairman.

Mr. ASHMORE. Mr. Hutchinson.

Mr. HUTCHINSON. Can you, Mr. Giordano, give us your real assessment as to whether civil commitment is going to throw any obstacles in the way of narcotics law enforcement or is it going to assist it in any way?

Mr. GIORDANO. Mr. Congressman, I don't think it would interfere at all with our enforcement. We have supported civil commitment of the addict for many, many years. We feel this is just another feature of attacking the problem.

Our job is to reduce the availability of the drug. But there is also a responsibility, I think, on our part, to see that the addict is treated. We aim our approach at the Federal level toward the important traffickers, interstate, international traffickers. Some of them are addicts, but we feel also that you are not going to solve the problem unless you also do something to try to rehabilitate the addict. So we have supported commitment of the addict.

I, of course, have supported it for a long time and actually feel that more emphasis should be put on the commitment before they get involved in law violations. However, if they are involved in the type of violation, the type of individual is one that would benefit from treatment, we feel he should have treatment.

Mr. HUTCHINSON. Pursuing Mr. Grider's line of questioning, he asked you to comment about the willingness of these addicts who would rather take 30 to 60 days in jail and get back on the street. I take it they don't have any real desire to voluntarily get the cure. Now then under this system of civil commitment, they are still going to be of that attitude, aren't they? They are going to have to voluntarily decide whether to take this civil commitment road or whether to take a jail sentence. Aren't you still going to have that same problem?

Mr. GIORDANO. Congressman, certainly we will have the same problem. As I indicated, if they are not involved in a violation, this is why we have recommended a compulsory commitment. If they are involved in a violation, and the penalty for the violation is substantial enough, that is going to be the compulsion that is needed to bring them around into taking the treatment.

Mr. HUTCHINSON. I don't understand that 9067 provides for compulsory commitment of addicts who have not been charged with the commission of a crime.

Mr. ASHMORE. You mean 9167?

Mr. HUTCHINSON. 9167. As I understand 9167, the administration bill, you don't reach anybody until they are charged with the commission of a Federal crime. The bill doesn't go as far as apparently you suggest, that there be a system of compulsory commitment of addicts simply by reason of their addiction alone.

Do you think that Federal power could reach that far?

Mr. GIORDANO. Well, Mr. Congressman, I don't know whether Federal power could reach that far or not. I know there has been some discussion as to whether the bill could be drafted which would be constitutional—some say, yes, and some say, no.

Our position on that has been that this is primarily the responsibility of the States in this area, that is compulsory commitment prior to any violation, such as the California and New York laws. For our purposes, we can do our part on the Federal side where we have violators of Federal laws, and this is not only narcotic laws, but where they forge checks or steal from interstate commerce. Those people should be given the option of deciding whether they want treatment or go to jail.

I mention the need for compulsory commitment prior to committing a crime as generally our position, not that we were advocating this in this bill.

Mr. HUTCHINSON. Thank you.

Mr. ASHMORE. It is not a Federal crime to use narcotics; is it?

Mr. GIORDANO. No, sir.

Mr. ASHMORE. It has never been.

Mr. GIORDANO. No, sir.

Mr. ASHMORE. Neither is it a violation of any State laws; is it?

Mr. GIORDANO. Not any more. At one time prior to the Supreme Court decision, some States had an act that would make it a crime to be an addict. However, that has been ruled unconstitutional.

Mr. ASHMORE. On the rehabilitation phase of this thing, which is another very vital part of the program, what do you—or would you recommend some method, or some policy, whereby these people, when they are determined cured and released from the institution, or by the Surgeon General, Department of Justice, or whoever might have them, to go back to civilian life, what about a program that would place them in some other environment, rather than returning to the old habits and friends where they have been for all of these years, when they were participating in the use of it?

Mr. GIORDANO. Mr. Chairman, I think this is really the key to the civil commitment. It is not so much the hospital treatment which is difficult, because they have found that this is relatively simple, the removal of the addict from drugs and so forth. It is the period of time when they leave the institution and go out into society again, and this is where there has to be very close supervision. Most of them have no vocation, they have to be taught a vocation, they have to be helped to find a job, somebody has to make sure they are not falling back with their old associates and their activities need to be followed for a fairly long period of time.

If they can do this successfully—and it will be a concentrated form of supervision, much more of a supervision than you have with the ordinary parole individual.

Mr. ASHMORE. Could that be set up under the present parole system and administered, do you think?

Mr. GIORDANO. Parole authorities say they can do it.

Mr. ASHMORE. They say they can do it?

Mr. GIORDANO. Yes. New York State, I may say, Mr. Diskind, who is head of the parole setup in New York State, had a pilot project

and he is still expanding. When a parolee, who is an addict, comes out of prison, he has a very close supervision.

In other words, the agent that is supervising him will have only maybe 15 individuals that he supervises rather than 50 or 60. And they have had some good results in preventing relapses with this very close supervision. So I don't see any reason why the Federal parole couldn't do the same.

Mr. ASHMORE. What do you think of a coordinated program with some of the Great Society programs that are now being advocated, OEO, whatever it might be, whereby these people could be assisted under these programs and maybe moved to another area and provided some means of livelihood until they get a job that would provide a living for their family?

Mr. GIORDANO. Mr. Chairman, I think they are going to have to use all of the facilities we have in this program.

Mr. ASHMORE. It is going to take more than what we now have, I believe.

Mr. GIORDANO. Right.

Mr. ASHMORE. Would you gentlemen agree to that?

Mr. ACHESON. I would certainly emphasize that the success of a treatment program, following commitment, really is more a question of available facilities than it is a question of your legal authority to take various steps. A good example of the gap between legal authority and facilities that make the authority work is here in the District of Columbia, where there is a statute, which is a satisfactory instrument for civil commitment of persons not under criminal charges, who are addicts, and also a satisfactory instrument of probationary treatment of addicts, who are under criminal charges.

The trouble is, there has never been any facility that makes this system of treatment possible except hospitalization in the District of Columbia General Hospital. And their experience has been that relapse occurs so quickly after the addict is released from the hospital that to keep him in the hospital, using up bed space, really is a meaningless exercise. So that has become a revolving door and, as a result, the program of hospitalization under that statute has virtually stopped. And it really makes no sense to begin it until there is a system of facilities that can follow the addict further out into his readjustment to his own life.

Mr. ASHMORE. What do you have in mind in the way of facilities, Mr. Acheson?

Mr. ACHESON. Well——

Mr. ASHMORE. Something we do not now have?

Mr. ACHESON. Yes, something we do not now have. Something in the nature of a progressive release of the addict, and a progressive series of steps of supervision, so that when you get him out of hospital residency, you get him under the care of a facility where perhaps he checks in every day, or may spend an occasional night, and then perhaps you can turn him over to another system that has vocational assistance, where he checks in once a week, and have people following him with a long enough string so that as the supervision becomes looser and looser, you are still able to tell whether he is responding to the treatment or whether he is relapsing.

Now, the 36-month period may or may not be long enough. But I think before we contemplate moving people from one community to another, we might see what a 2- or 3-year supervision can do in their own community.

Mr. GILBERT. Mr. Chairman.

Mr. ASHMORE. Yes, Mr. Gilbert.

Mr. GILBERT. The facility that you just mentioned, is that a facility within the community, where the addict resides, or is it outside of his community?

Mr. ACHESON. Well, I had in mind ultimately a facility that supervised him in the community, not necessarily where he did reside, but where he resides and is seeking work.

I think most people believe that until you can get an addict working and concentrating on something besides his own problems, you are not really going to get him permanently off of drugs. He is a potential addict, as long as he is unsettled and not preoccupied with something productive.

Mr. GILBERT. I agree with you completely; yes. That is why I am most interested in this program that you envision, where he would be under supervision for 36 months and then go back daily practically, you say, or every other day, to this facility. Of course to me it is most important as to whether this occurs in the community where he resides or he reports to a central agency located somewhere in a large city or wherever it might be.

As I have expressed on numerous occasions, I think the problem relates back to his very environment, and if he is returned back to this environment, I think you have a tremendous uphill battle and practically a losing battle, because all of the social ills and the problems that beset him at the time he became a drug addict he is faced with immediately upon his return.

I was curious if there was any relief in this area, or any solution that you can see to this problem.

Mr. ACHESON. Well, I think the California program will teach the Federal authorities quite a lot in this. And it may be that some of the private programs going on around the country may either eliminate or perhaps point to certain methods of treatment that will be successful or unsuccessful.

Mr. ASHMORE. Isn't one of the first problems getting him employment, a job? It appears that if he is, like many of them, if he is incapable of performing any labor of much consequence when he goes in—and that is usually the type, isn't it, he is not very well versed in earning his own living or doing any sort of work that is of much value—wouldn't he first have to be rehabilitated and trained by some governmental agency to do a job and then he can get a job, or is there a stigma attached to him, like if he had been a highway robber or had a dishonorable discharge from the Army and so forth? What would the employers do? Would they take him or not?

Mr. ACHESON. It is very important that that problem be licked, Mr. Chairman. Very important. I frankly don't know what most employers would do. It depends a lot on the encouragement they are given, and on who the employer is.

Obviously you or I would prefer to hire a person who was not a narcotic addict and never had been.

Mr. ASHMORE. What about New York and California? Are there any statistics on that?

Mr. GIORDANO. I don't have any statistics, but apparently I can say that it is difficult to get these people jobs; however, it can be done. They are doing it. But it is very difficult, because employers have this idea that they are addicts, or were addicts, and it does affect it. But they can get them jobs, and I may, in talking toward Mr. Gilbert's point there, say I think these people, when they come back, may come back to the same city, but certainly not to the same area that they came out of in the city.

I think this would be very bad if they went back in with the same people. And it may be that experience will find if their ties, their family ties, are such that they could be moved to a completely different area of the country. This may be more beneficial.

Mr. HUTCHINSON. Mr. Chairman, if you will yield, isn't it quite likely that if an addict coming back into say, the same city, but into a different community in the same city, that the old gang and so on will make efforts to contact him? Isn't he always going to be in the position of having to ward them off somehow? Won't they try to get him back on the stuff and so on?

Mr. GIORDANO. I would say, Mr. Hutchinson, that he would make an initial contact with them before this would happen. Of course once he did, once he made that initial contact, he would be back on the same merry-go-round. But I would say there would have to be an initial contact.

We have seen people who have been in jail and some people that have been able to rehabilitate themselves, and they have been in the same city in a different area, with a job, and no association with former colleagues. But if they go back initially themselves, well then this starts it all over again.

Mr. SHATTUCK. We had some testimony earlier in these hearings that one of the difficulties experienced with persons from large cities who were sent to Lexington or Fort Worth was that it was such an alien atmosphere that they felt out of place, they felt at home in the large city that they knew; this was their life. And to take them into an area, a completely new atmosphere, these people were not prepared for it. So maybe you have to split the difference some way. In other words, follow the course that you have outlined, that perhaps we must assume that they must go gack to the city, or general area, but not the specific group of questionable associates and so on that they have been associated with before.

Mr. GIORDANO. Well, practically all of the addicts are from big cities, and this is the life that they know. And I think most of them would have difficulty in adjusting in a small area. But they could be moved to another large city where they didn't have any associates before. This may still satisfy their desire for being in the type of community they want to be in.

Mr. MCCLORY. Could I ask one question, Mr. Chairman?

Mr. ASHMORE. Yes.

Mr. MCCLORY. With regard to the environment to which the addict might return and the supervision in that area, there wouldn't be any disposition, would there, to embody this in any way in the legislation? I mean we are talking about application of the legislation now, a practical problem.

Mr. GIORDANO. I think not.

Mr. MCCLORY. You wouldn't recommend that we require that the addict be returned to some other environment?

Mr. GIORDANO. Not at all, because this has to be flexible, so they can handle it the best way they can. I think if you tried to put something in and it didn't work, we would be worse off than before.

Mr. ASHMORE. But it is good to have it in the history of the legislation, so the people who are administering it will know what we had in mind and know we did give consideration to all of these problems.

Mr. GIORDANO. Yes.

Mr. HUTCHINSON. Mr. Chairman, if we might return for a moment to a statement that was earlier made, the observation that the Federal probation people think they can handle this job of aftercare supervision, do I understand that the reference in there was intended to cover these civil committed people? Does anybody see any problem in having the probation people, or the parole people, handling civil committed individuals?

Mr. GIORDANO. Well, as I understand it, one part of it is under the authority of the Surgeon General and under the other part it is the Attorney General. Now the Surgeon General may find it would be advisable to have his own caseworkers rather than parole officers, which would really be the same type of an operation, somebody that would supervise the individual when he is out.

Mr. HUTCHINSON. That is exactly the point I wanted to get clear in my mind. This legislation does contemplate the establishment of an organization running parallel with the parole organization, probation organization, within the Surgeon General's department, does it not?

Mr. ACHESON. I am not certain of this, but it would seem to me section 105 of the bill would allow the Surgeon General to turn over certain of his supervisory functions in the aftercare treatment to any other Federal organization that was staffed to take care of it. And I would assume he could make an agreement with the Department of Justice, or the Administrator of U.S. Courts, so that the probation staff would be able to perform supervision of the addict, as he was released into the latter stages of the treatment.

Mr. HUTCHINSON. And this wouldn't in your mind raise any conflict with this fine distinction between the appearance of a criminal charge as opposed to a civil commitment on the man's record?

Mr. ACHESON. Not in the least, Mr. Hutchinson. It is an open-end delegation of authority, as I see it.

Mr. HUTCHINSON. Fine.

Mr. SHATTUCK. Is this a problem with this legislation, the question of the division between civil commitment on one hand in title I, and sentencing to commitment in title II?

Mr. ACHESON. No, I don't think it is a problem at all.

Mr. SHATTUCK. It should not be, if I may be permitted to say.

Mr. ACHESON. I don't believe the way the bill is written produces a problem in that regard.

Mr. SHATTUCK. The emphasis should be on the nature of the aftercare and the facilities and counseling, and all of the other required supervisory activity of the Federal Government, that should be where the emphasis is placed.

Mr. ACHESON. Right. The important thing to do is is get some legal compulsion over the addict by one permissible route or another, so that you can impose a plan of treatment. And the bill provides reasonably neatly, I think, for getting one form of compulsion over him through the pretrial treatment route, and another over him through the post-conviction route.

Mr. ASHMORE. Doesn't it simply boil down to the fact that if he elects to take the civil commitment, he agrees to do or commits himself to a program as outlined or as administered, and if he refuses to follow the program, then he knows he can be brought back and tried for his crime. Is that it? That is hanging over his head all of the time.

Mr. ACHESON. That is right, Mr. Chairman. And in addition, an addict who doesn't elect under title I, can still be treated after his sentence under title II of the bill. So you can handle him two ways.

Mr. HOFFMANN. Mr. Chairman?

Mr. ASHMORE. Mr. Hoffmann.

Mr. HOFFMANN. I wonder if I could at this point in the record make a partial observation and ask a question. Last year the work release legislation that was enacted by the Congress applied to nonnarcotic offenders, or to the Federal prisoner generally. Various enlightened rehabilitation features were included, such as halfway houses, which I think are being set up now on a demonstration basis, emergency visits from the prison, and even—at the advanced stages—the short furloughs home. The program, of course, assumes continuing probation thereafter.

Can it be assumed that any new facilities you would contemplate, Mr. Acheson, would be directed to the civil commitment rather than the postsentence aspect of the proposed legislation?

Mr. ACHESON. Well, I would assume so. I must defer on expertise here to the Surgeon General, and his testimony appeared to contemplate maybe an expansion of the kind of halfway house program that he referred to in Houston.

This is something in which I think frankly the people charged with treatment are going to have to feel their way along and see what works.

Mr. HOFFMANN. But you would see no objection within this framework of just superimposing the civil commitment program, the care and treatment and supervision, into this work release program at the proper level, as the addict indicated he was ready for it?

Mr. ACHESON. That is one set of facilities they might very well use, sure. I think they will have to use all of the facilities they have, and perhaps create additional ones.

Mr. MCCLORY. Mr. Chairman, may I inquire?

Mr. ASHMORE. Yes.

Mr. MCCLORY. I would like to ask a couple of questions. One is your opinion as to whether or not this civil commitment legislation would have the effect of reducing the number of narcotic cases or reducing the narcotics problem? Do you feel it would tend to reduce it, or are you fearful that it might provide a way out for offenders that would really increase your problems?

Mr. ACHESON. Well, I am going to ask Mr. Giordano to add to what I will say. But it would seem to me that under this bill you can screen out of the election and treatment process the people that aren't treatment problems, or are not promising cases for rehabilitation:

The crimes of violence, the narcotic traffickers. As well as words reasonably can, I think the bill opens the door for treatment to the kinds of cases where you are likely to do some good with treatment. And I think there are safeguards in the bill that ought to be effective to guard against an addict using the election as a way of getting out of prosecution, because he can't do that more than once without making himself ineligible. Secondly, the examination performed on him, which must be reported to the court, would not only include a physical and mental examination, but somewhere along the line I assume the court would have cognizance of his earlier criminal record, and all of this would come into the judgment of whether he was likely to benefit from treatment.

Mr. McCLORY. Is your——

Mr. ACHESON. And the court can control that. It is not an open-ended election process. The court can divert him from the treatment process, if there is a finding he is not a likely subject for rehabilitation.

Mr. McCLORY. Is your opinion supported by any experience in New York or California, or any other country?

Mr. ACHESON. I would have to say my experience is all vicarious in this field, Mr. McClory.

Mr. McCLORY. I am not talking about your individual experience, but I am talking about the experience in California or in New York, or any other country. Does it support your opinion, do you know?

Mr. ACHESON. I would say the situation in New York probably does support it, because there is an essential difference between this bill and the situation in New York. If you have to choose between a misdemeanor or prosecution, that is, you are a criminal defendant, and you have to choose between a misdemeanor or prosecution, where you get less than a year, maybe 6 months at the most, and on the other hand a course of medical treatment which will put you under legal compulsion and maybe behind walls for a much longer period, you would probably choose the misdemeanor prosecution.

Now this bill poses an alternative to treatment which will cause the addict to think a great deal longer than he has to in New York, because the alternative is a felony prosecution, in which the mandatory minimum penalties of the narcotic statutes apply. And I think it is very important—and this goes to the penalty provisions of the narcotic statutes and of this bill—it is very important as this bill does to keep the mandatory minimum penalties up to rather intimidating strength, in order to make the alternative to treatment one which the addict will not choose to elect. And that is why I think the treatment program would be effective under this statute.

And it wouldn't become a route for evaders.

Mr. McCLORY. I know the narcotics problem has many facets. We are concerned with narcotics traffic; we are concerned with the enforcement of narcotics laws against the narcotics offenders; and we are also concerned with the addicts who would be in this group as well as other addicts that we are not covering in this legislation.

Do you have any other legislative recommendation, or do you, in your experience, sense any shortcomings insofar as legislation is concerned? I would like this committee, in the course of our work and our recommendations, to spread out into other subjects of new laws to impede the traffic or to revise the enforcement, or the penalty structure

of the law or any other aspect of the law. I just wonder, now that you are here and I am here, whether you have any other legislative recommendations?

Mr. ACHESON. Well, Mr. McClory, there are a number of pieces of legislation going to criminal enforcement in general on which we are submitting comments. There are a group of these bills, for example, in Senator McClellan's committee, we are submitting comments on those. I understand that on the Senate side, Senator Dodd is going to have further hearings on a group of narcotics rehabilitation bills. But if your question goes to any sort of legislative aid to criminal enforcement, including narcotic trafficking, I think there are proposals that would benefit enforcement, and we expect to submit a report on a number of those bills.

I am thinking of six that were introduced by Senator McClellan and in time I am sure, when they are heard on the House side, we will have a lot to say about them.

Mr. MCCLORY. Have you made any recommendations to the President's Special Committee on Criminal Laws?

Mr. ACHESON. The President's Commission on Enforcement and Criminal Justice?

Mr. MCCLORY. Yes. He has a special committee, what is it called? Have you made any recommendations to that committee?

Mr. ACHESON. Well, that committee so far is not in the business of getting formal legislative recommendations, but collecting facts. And we have submitted a tremendous quantity of factual material to them, including some proposals, not drafted as bills, but suggestions on various legislative tacks. I assume they will make their own legislative recommendations to the President.

Mr. MCCLORY. The facts in the report that you gave, together with the recommendations that you made, do you feel they would be important for this committee to consider in connection with the general subject of narcotics law amendment?

Mr. ACHESON. There is a lot of pretty raw data there, Mr. McClory. And knowing how swamped that Commission is, and how swamped its staff is with the material it is getting, I doubt really whether it would help this committee to have a similar flood of documented information coming in on the whole wide ranging field of enforcement.

Mr. MCCLORY. You are satisfied that this legislation might be considered and enacted independently of other aspects of the narcotics law?

Mr. ACHESON. Yes. I feel this bill deals with a separable and reasonably self-contained piece of the narcotics problem. There are other pieces of the narcotics problem that Commissioner Giordano knows more about than I do. This deals with one piece of it. And I don't really see that this bill should await the outcome of a lot of other legislative projects, which I don't think affect the rehabilitation question a great deal.

Mr. HOFFMANN. Could I ask a question along this line?

Mr. ASHMORE. Yes.

Mr. HOFFMANN. There have been proposals by the witnesses from both California and New York that we put into this legislation rather strict penalties for either going off aftercare or disobeying lawful orders by probation authorities, or the civil commitment supervisory

staff. The object would be to allow prosecution of a fresh case instead of having to track back maybe 2½ to 3 years and prosecute a rather stale indictment.

Do you have any comments on the efficacy of such a procedure? Would you like to see this in the bill?

Mr. ACHESON. Well, there is something to be said for that, Mr. Hoffmann. One of the problems with it is that the type of thing that is likely to make treatment ineffective in a particular case might in a large number of situations not be the kind of thing you can prosecute as a crime. If you don't have—well, obviously you can make it criminal for a man not to respond to his appointments with his probation supervisor, but it would be hard to make it criminal and certainly very hard to prosecute under the Constitution and just as an evidentiary matter, the simple failure of the guy to pull out of his narcotics addiction, or his failure to get a job, or even his failure to be cooperative, I have a feeling that there would be so many doors of possible failure open that couldn't be closed by prosecution that I just don't know what you would gain by the California suggestion. But it makes sense as a conceptural matter to prosecute a fresh crime. But it will be a problem to go back on an old case, if treatment should not work out.

Mr. SENNER. If I may interrupt, counsel, didn't you have in mind something more in the contempt of court nature, rather than making some act a crime, so that we would have this lever of compliance subject to probation?

Mr. HOFFMANN. This was one of the proposals made for doing that same thing.

Mr. SENNER. Rather than reaching out and creating a new crime for insubordination or something of that nature.

Mr. ASHMORE. Mr. Shattuck, do you have a question?

Mr. ACHESON. Could I add just one brief thing to my answer to Mr. Hoffman? I am reminded that of course in the part of the bill that deals with narcotics treatment after sentence, where a defendant is taken to prosecution, sentenced, and is an addict, and the treatment follows his sentence through the prision system, then he is subsequently released on parole, of course you can use the regular parole string on him to enforce the terms of the treatment. And if he doesn't cooperate in the treatment, you can retake him on a parole violator's warrant, since he has violated one of the terms of his parole.

But I don't suppose this would deal with the civil commitment cases.

Mr. SENNER. You don't think it is broad enough in the bill as presently written to deal with this under civil commitment? Is that your testimony?

Mr. ACHESON. Well, the postconviction type of parole, no, would not apply to a civil treatment.

Mr. SENNER. Would you recommend this committee put language in that would make it applicable? Such as contempt of court under civil commitment, if they fail to comply with the probationary terms?

Mr. ACHESON. Well, I don't think that you could. I think as long as the court's order places him in the custody of the Surgeon General for treatment, you have got some protection there. The Surgeon General, if he finds that half-way house or out-patient rehabilitation is not

working, I suppose he can put him back in the hospital and that is some protection.

Mr. SHATTUCK. On this general point, Mr. Acheson, previous testimony and, in particular, I believe, it was testimony by witnesses telling of the experience under the New York law, we were advised that in some cases these people would merely disappear, they would lose themselves in New York, and the police force were overburdened, and it was not possible to go out and find these people, and this was another lack in the program.

Was this not possibly a factor in the proposals that Mr. Hoffman referred to, that it is a definable act that goes beyond the question of not completing treatment, it is a simple elopement, whatever you want to call it, where the man merely, not only does he not report, not only does he not cooperate, he just leaves.

Mr. ACHESON. Yes. Well, under the Federal bill the Surgeon General would have the authority to return a man who is on conditional release to a hospital if he thought he should.

Mr. SHATTUCK. This is a man who says "I will not do anything you say."

Mr. ACHESON. And to recapture him if he should elope from the hospital. But if you are getting to the point of recapturing people who run away from the hospital, I think you might as well face it, you have a case on your hands that is likely to not work out for rehabilitation. And it may be that you ought to wash it out and go through the criminal route as soon as you can.

Mr. SHATTUCK. Or at that point, sir, the proposal was, I believe, to make that a criminal offense. Do you have any comment on that?

Mr. ACHESON. I see an advantage in making that a criminal offense.

Mr. SHATTUCK. Thank you very much. Mr. Gilbert, you had a question?

Mr. GILBERT. Yes. Mr. Acheson and Mr. Giordano, I am just curious as to your opinion about how many persons would be affected under the civil commitment portions of this proposed legislation?

Mr. GIORDANO. Well, really I couldn't give you a complete answer unless I knew the total number that were in the penitentiary for other offenses. But as I gather here, it would affect—we have 40 percent of the cases we make which involve addiction. Now, of course, what number of those would be subject to treatment is something else. Now, we run about 1,600 cases a year. So that would be around 500, between 450 and 500. And, of course, you would have to wash out of that the number that would be restricted because they were involved in sales or they had second felony convictions, and so forth.

We don't have any accurate figures on this.

Mr. GILBERT. It doesn't appear to me that a great number of people are going to be eligible under the commitment, civil commitment section.

Mr. GIORDANO. I would say that there certainly will not be a great number of those that have committed narcotic violations. However, I do foresee that there may be a larger number among those that are involved in stealing Government checks, or forging Government checks, in interstate commerce, and so forth, stealing from interstate shipments. And, of course, as I understand it this is a substantial number——

Mr. GILBERT. It is a substantial number?

Mr. GIORDANO. So I understand.

Mr. GILBERT. This is something I have never been able to ascertain.

Mr. GIORDANO. I do understand it is a substantial number.

Mr. GILBERT. Do you have any statistics as to the number of people that were committed to Lexington or Fort Worth, as to what percentage of these people finally return back?

Mr. GIORDANO. Well, I think Lexington says that 90 percent revert. This, of course, as the individual gets older, this figure drops. A study was made of the addicts from Kentucky, where they could really check them, and it was found that initially there was about a 90-percent relapse, and then as they came back the second or third time and were in the 40 to 50 age group, the rate of relapse dropped to about 40 percent.

Mr. GILBERT. But how many addicts—of course, it is all on a voluntary basis, going to Lexington.

Mr. GIORDANO. They have no followup there, of course.

Mr. GILBERT. I undersand that. I know, for example, that many parents have spoken to me in my district about the fact that their child voluntarily committed himself to Lexington, in order to avoid prosecution in the court, and so on, but they stay there a very short period of time and they are out.

I wonder if there are any statistics as to how many of these addicts actually complete their course of treatment.

Mr. GIORDANO. There are statistics. I don't have them available. The Public Health Service does have them. They have the percentage of those that leave within a month and the percentage that leave within 2 months. The percentage that leave is very high within the first month, and then it gradually goes down. At one time there was a law in Kentucky called the Blue Grass law, which was utilized very effectively by the volunteer addict until the Kentucky Supreme Court ruled it unconstitutional. When addicts arrived in Lexington they were immediately processed through the local court under the Blue Grass law, given a suspended sentence, and then released to the institution, with the understanding that they remain there until the doctors released them or else they were subject to the sentence imposed. During that period of time there were not very many addicts leaving early. But as soon as the law was held unconstitutional, addicts again started the early departure routine from the institution.

Mr. GILBERT. As experts in this field, and I address this to both of you gentlemen, do you honestly feel that this legislation is going to really cut into the narcotic problem?

Mr. GIORDANO. I think the answer to that question is that we think this is just another step forward. I certainly don't think that this is going to make a very dramatic approach to it on the Federal level. But I do think that what it is going to do is to encourage the States in this direction, and with the overall approach to it we are going to move in the direction of not only the enforcement area, which is our prime interest, which we will continue, which we hope to press even further, but will do something in the area of treating the addict, which we haven't done. And I think it is a first step.

Mr. ACHESON. I agree with that, Mr. Gilbert. It seems to me there are a lot of different narcotic problems. There is the problem of the trafficker, which this won't touch much, the problem of the hardened

criminal who is an addict, which this won't touch much, and the problem of the more or less recent addict who has got some material worth trying to rehabilitate.

Now on that problem I think the bill is a hopeful start. Whether it will succeed in a large number of cases, nobody can say.

Mr. GILBERT. I am inclined to agree with both of you gentlemen's observation. I know I visited some of my local precincts in New York, where they have made an arrest almost, oh, within an hour or so before I went through their detention pen, and invariably the narcotic that I found in there—and I don't know what the drug was they were using, barbiturates or marihuana or what—almost all of them would say, "Gee, I am not hooked. I can go off at any time I want." So perhaps a bill like this would be a great savior for many of these fellows that have that attitude.

Now they may be saying that in order to prevent prosecution you see. But I was amazed. And this was almost every one of them I spoke to in the detention pen.

Mr. ACHESON. Well, I see a good deal of promise in double-checking the election the defendant makes here with an examination which will comb his criminal record and his mental and physical state of being to see whether he is the kind of material you can do much with under the bill. And it is important to me that the judge has the last word on that, not the addict.

Mr. MCCLORY. Will the gentleman yield on that point?

Mr. GILBERT. Surely.

Mr. MCCLORY. The bill doesn't cover users of barbiturates and marihuana, does it?

Mr. ACHESON. No.

Mr. GILBERT. Is it easy to detect? A person is arrested and he says he wants to come under the provisions of the law, and he says, "Well, I am a narcotic addict, and I ask for this, I apply under the section of this bill." Can the Surgeon General's Office or physicians readily ascertain whether this person is a user of narcotics or not?

Mr. GIORDANO. Yes. They can, because the withdrawal syndrome appears, whether it is mild or severe. Of course, today most of them, and this gets back to your earlier statement about the individual saying, "I can take it or leave it, or get on it and get off," today the purity of the drug that is on the street is away down, and this is true even in New York. In some areas it is 1 or 2 percent heroin. In New York it runs now I guess about 8 percent. But it was down for a period of time to 5 percent. And during this past year there was a period of about 3½ to 4 months where they referred to a panic in New York. This didn't mean to say there wasn't any heroin available at all, but it was in very short supply, and very weak. But even when it is weak, the physicians can determine whether or not they are a user of narcotics.

Mr. HOFFMANN. Could I interject a question?

Under the provisions of 9167, and as the Justice Department representatives pointed out at our last hearing, there may be in many cases a period of 30 to 60 days before the addict under the bill is in a position to elect civil commitment, thereafter to be put under the Surgeon Generaal's care to ascertain, among other things, whether he even is an addict.

I wonder if you would comment on the efficacy of that provision in light of what you just said about the vanishing narcotics and the low incidence of the really hard core addicted arrestee.

Mr. GIORDANO. As I understand the bill, we have a period of 5 days for election.

Mr. HOFFMANN. After he gets to the judge. Now if he is presented to a commissioner, to have a preliminary hearing, the commissioner either commits him, and he makes bail or doesn't make bail. Before he is arraigned on whatever indictment comes down, unless he volunteers, it may be 30 to 60 days. If he makes bail, are we going to have a really accurate picture of whether he has always been an addict or maybe just got on the habit in the interim to try to come under this legislation? Do you think that is a problem?

Mr. GILBERT. I may say I don't think bail is permitted under this bill.

Mr. HOFFMANN. It was pointed out it would be.

Mr. GILBERT. I thought, as I read the bill—I may be wrong, of course—that after he makes his election, there is no bail permitted.

Mr. ASHMORE. After he makes the election. But he is talking about before he elects.

Mr. HOFFMANN. My question is directed to the circumstances obtaining in the District of Columbia, where he goes before a commissioner. He is not before the district court as is spelled out in 104(a) for the warning and to make his election.

Mr. GIORDANO. This could develop into a problem as to the period of time there. I had generally assumed that when they were brought before the commissioner, if they were an addict, the U.S. attorney would be available to indicate to them at that time what the possibilities are, and certainly if the person was interested in accepting a waiver of indictment and agrees immediately to go, before the judge, this may have a lot of bearing on the evaluation later on, as to the intent of the individual and whether or not he was a good subject for rehabilitation. If he just waited and waited and finally came up at the last minute and said, "Now I want treatment," his intentions may be suspected.

Mr. HOFFMANN. Would you have any judgment as to how many of these some 1,300-odd arrestees that you have in a year would be presented to a commissioner? How many other cities have the same Federal setup that they do in the District of Columbia?

Mr. GIORDANO. All of ours have to be presented before a U.S. commissioner.

Mr. HOFFMANN. So with almost all of your arrestees, this 60-day period, depending on how long it takes a grand jury to get an indictment out, this 60-day period might obtain.

Mr. GIORDANO. We have many areas where the first thing is an attempt to get a waiver of the grand jury. And a good number of the judicial districts, this is the way they primarily operate. If the individual has an attorney immediately and is willing to waive grand jury, then they bring him in immediately an an information.

Mr. ACHESON. May I add to that answer?

I don't think that we have to fear that the waiting period will be the entire period between appearance before the Commissioner and indictment. Because it would be possible, not only possible, but highly pos-

sible for a district court to arrange it so you had a hearing calendar before a judge under this statute, a person charged before the commissioner could be brought promptly, if there were thought to be any addiction problem, before a judge to make an election.

Mr. SHATTUCK. Couldn't they not require he be brought before the judge rather than a commissioner?

Mr. ACHESON. Not in the first instance, I wouldn't think, Mr. Shattuck. The normal hearing on the criminal charge takes place before a commissioner. It is just not feasible to bring all of those before a judge.

Mr. SHATTUCK. In those jurisdictions where there are no commissioners, the first appearance would be before a judge.

Mr. ACHESON. Well, of course, the big addict problem, we are really talking about three cities, where you have a multijudge court and plenty of commissioners. But I would think the court could hear these elections promptly by a special hearing calendar, much the same way where a commissioner grants bail in a criminal case now, a motion to reduce the bond is very often brought before a district judge in a few days after the commissioner's hearing.

Mr. HOFFMANN. Could a man be produced on motion by the U.S. attorney, and perhaps even committed between the time he got to the commissioner until the couple of days in which it would take to get to court?

Mr. ACHESON. Very easily. As a matter of fact the analogy in the kind of proceeding you would have under this statute and the kind of proceeding you would have before a district judge on a mental commitment and examination is pretty close. You usually don't know much about the mentality of a defendant, when he is first brought to the commissioner. But a couple of days of checking around at the hospitals, and the police record and so forth, may tell you more. Or his behavior may tell you more, as it may be the addict. And you may have the basis in a couple of days for a motion to have him appear before the judge and have the hearing under this bill.

Mr. HOFFMANN. Do you think there are the same touchstones of danger to himself, and some sort of public health problem with the fact of addiction per se that would give the Federal authority power to involuntarily commit, as it now can on a reasonable showing for mental observation?

As I understand the testimony, the average addict is going to want to get back out on the street. And if he sees a way to post bond and get back immediately, the authorities won't be able to hang on to him long enough to run accurate tests.

Mr. ACHESON. I don't know. Under this bill, Mr. Hoffmann, it seems to me that the court probably could not order a commitment for examination until after the election is made. So it would be very important to get the hearing on before a judge a day or two after the commissioner's hearing if you could.

Mr. GILBERT (presiding). This is actually administrative, and I think between the court and the U.S. attorney's office it could be worked out very easily.

Mr. ACHESON. I agree. There is nothing in the bill to prevent the court from setting machinery up to make it work.

Mr. GILBERT. That is correct. I don't think you would have to specifically spell it out in legislation, but rather the report of the committee and suggestions to the Department of Justice and the courts could work it out.

Mr. ACHESON. And, of course, what is good in one district might not be good in another, if you spelled it out.

Mr. GILBERT. Yes.

Mr. HOFFMANN. Would you assume under this legislation if the man came in and said, "I want to be in the best position possible to make my election and I would like to be committed right now for a study to see if I am an addict"—in your judgment could the authorities do this now under this bill?

Mr. ACHESON. Yes; I think so.

Mr. HUTCHINSON. If the gentleman would yield a moment, section 102, as I read it, seems to leave this entirely up to the U.S. district court as to whether they are even going to offer this man an election, because they say, "If the court believes that an eligible individual is an addict, the court may advise him." So the addict doesn't have any rights in the matter, as I see it, as to whether or not he is going to even have an opportunity to make an election.

Mr. SHATTUCK. The judge has a right of refusal, isn't that the inference in that language?

Mr. ACHESON. It would appear so. I suppose if the defendant or his counsel brought information to the court's attention that suggested that he was an addict, a court would then have to decide whether this election should be offered. I frankly don't know, if I were a judge, I would offer it, I would give him these instructions provided by 102(a), as soon as I had information that indicated he might be an addict. Then if a subsequent examination indicated he was not, or that he was a professional criminal or a bum or somebody who would not respond to treatment, then I would not order the treatment. But you are absolutely right, the statute is worded permissively on the instructions to the addict. But I think most judges would feel they really ought to give it.

Mr. HUTCHINSON. On the other hand, since the statute would be worded this way, permissively, the addict wouldn't be in any position to go up to a higher court and complain and claim he had been denied his rights, because he hadn't been offered the election.

Mr. ACHESON. No. Of course, it is up to the judge anyway to determine whether treatment should be allowed. But an addict, I think, would have ground to complain if the fact of his addiction and his eligibility for the instructions to be given him under 102 had not been considered by the court. If he could show that the court had been given information that indicated he was an addict and didn't do anything about it, I think you would have a point on appeal that the judge had not exercised the discretion that was given him by the statute.

Mr. HUTCHINSON. Then would you recommend that that word "may" on line 19, page 4, be changed to read "shall," the "court shall advise him"?

Mr. ACHESON. No; I don't think I would. I think I would leave it to the judges to play it safe.

Mr. SHATTUCK. What appeal are you referring to? Appeal on the criminal charge?

Mr. ACHESON. Yes. If the situation arose in which there was information the defendant was an addict, and the judge either did not give him these instructions, provided for in 102, or—yes, did not give him those instructions and never considered the fact of his addiction, just went right on with the prosecution, and then he was convicted in the prosecution, he would probably assert on appeal that he showed the court facts that brought him within the provisions of this statute, and the court did not consider or exercise the discretion it had under this statute.

Mr. SHATTUCK. Yes. That is the point I was seeking to reach. It is a discretionary act on the part of the court.

Mr. ACHESON. That is right.

Mr. SHATTUCK. It does not relate to the criminal charge, however.

Mr. ACHESON. The court doesn't have to go one way or the other, but the court has to exercise the discretion given it by the statute and make some record indicating it considered material, and it made a decision one way or the other for a reason.

Mr. GILBERT. What I am really concerned about, if there is an immediate appeal, that is one thing, but what happens in many instances, years ago by and this fellow is sitting in the can someplace and he speaks to one of these jailhouse lawyers and the next thing you know, you are faced with a coram vobis, for the simple reason he comes around and says, "I wasn't advised of my rights."

Mr. ACHESON. Exactly. I think the intention of the court to play it safe by considering his eligibility is reinforced by the declaration of policy on page 1 of the bill, which says:

It is the policy of Congress that certain individuals should be afforded an opportunity for treatment, if it is determined they are narcotic addicts—

Mr. SHATTUCK. Yes. The thing that bothers me is that it does not go to the criminal charge or the procedural aspect of the trial itself, nor does it go to any part of that. This is a procedure whereby all of that aspect of the case will be held in abeyance pending a treatment on a civil basis.

I was just wondering, since it is a civil proceeding by definition, how can action on a civil proceeding affect a subsequent conviction on a criminal charge.

Mr. ACHESON. That isn't the situation I was speaking of. The situation I was speaking of was where the court does not order the civil commitment and treatment, but treats him—either doesn't think he is an addict in the first place, or determines he is not eligible or would not benefit from treatment and then they go ahead with the prosecution. So you do have a conviction and you do have a criminal appeal.

And the question is whether the preliminaries that brought you to the fork in the road should have been considered by the court.

Mr. SHATTUCK. Your point goes to the fact, not to the result of the exercise of discretion——

Mr. ACHESON. Not the result, only whether the determinations that a court must make were in fact made.

Mr. SHATTUCK. Yes. And I think it would be a difficulty with this legislation, if we were to institute something which could have the effect, such as Mr. Gilbert has pointed out, that at some time, some years later, they could point out that some action was taken in connection

with civil commitment, whatever it might be, some aspect of this civil commitment procedure, which would then be raised as a technical objection to an unrelated criminal proceeding.

Mr. ACHESON. I don't think it is a fault in the legislation, Mr. Shattuck. In almost any litigation framework now, wherever the court has a discretionary act to perform, in which it can go either way, it is possible to argue, if the record is right, that nevertheless the court had to exercise its discretion and show it made the determination.

Mr. SHATTUCK. It has to be, in fact, an exercise of discretion, it cannot be ignored.

Mr. ACHESON. Yes. I would leave it discretionary in the statute and leave it to the judges who are alert to this problem to make it plain they exercised the discretion they had. There isn't any way you can avoid that problem.

Mr. GILBERT. I don't know if I am not inclined to agree with Mr. Hutchinson on the reading of section 102.

If the U.S. district court believes an eligible individual is an addict, the court may advise him * * *.

Now this is not a mandate upon the court to advise him. And if a court or judge in his wisdom determines that, well, I am not going to say anything to this individual, I am just going to keep quiet about it, and he has a perfect right to do it under this statute, and as a result this particular defendant would never become subject to the provisions or couldn't become subject to the provisions of the civil commitment. Now, can this party say, subsequently, "Well, I was never advised of my rights," the same as you say, "Well, the court didn't advise me I had a right to an attorney, I had a right to this or that," and, therefore, we are going to open a wide avenue of appeals for these people?

Mr. ACHESON. No; I don't think so.

Mr. GILBERT. That disturbs Mr. Hutchinson, I am sure.

Mr. ACHESON. This problem is in the bill, but it is in every preliminary and criminal proceeding right now, on the question of mental competency, for example, a court has the discretion, in the Federal system, to either order an examination for mental competency or not, unless, you know, the record is terribly heavy. But the fact is the law requires the judge exercise that discretion. If the record shows he considered the question and resolved it for a reason that was sufficient to him, he is all right. If the record shows he forgot it, or wasn't aware of the statute, never considered the question, then he is not all right. And there is no way to escape that problem by the way you draft this bill. It is inherent in the situation.

I think the way the bill is drafted handles it the best way you can.

Mr. HOFFMANN. Let me take you a little further along this procedure.

The judge either plays it safe or follows the statute as amended, and he warns the defendant. The man is sent off to the Surgeon General. Then the studies come back and the judge is now to make a determination whether the man gets a civil commitment or not. At that stage of the proceeding, what do you envision in the way of a hearing requirement? This is where his eligibility under the act is being determined and the criteria as set out in the act will have to be applied by the judge.

Mr. ACHESON. The subsection (b) there says, "If the court, acting on the report, and other information coming to its attention, determines that the individual is not an addict," et cetera. Now the swing phrase there I suppose is "other information coming to its attention." And I suppose that information has to come to the court's attention through some orderly procedure and I would assume through a hearing.

Mr. HOFFMANN. The judge is going to have to let the defendant in this case know why he disqualifies him, is he not?

Mr. ACHESON. I would think so.

Mr. HOFFMANN. Now suppose it gets down to a question of whether or not he may have sold for the primary purpose of securing a narcotic drug which he requires for his personal use, under section 101 (g) (2). He produces three friends and the neighborhood clergyman to say he usually goes straight, he has about an $8 a day habit and isn't a commercial type. The defendant was caught with five or six caps in his possession and for all that appears, he only is selling a little bit of drugs, just enough to keep his own habit supported. Now don't you think we are in for a hearing on that issue, once he has made this proffer?

Mr. ACHESON. Yes; I would.

Mr. HOFFMANN. Once we get to that stage, are we in any trouble with the resources that the U.S. attorney is going to have to combat this proof?

Mr. ACHESON. Well, it isn't the most precise factual question in the world. I think it is a troublesome question. I can see plenty of evidentiary problems coming up. I am not sure they wouldn't be just as serious for the defendant, though, as for the U.S. attorney. That would lead you to the question of who has the burden of proof.

Mr. HOFFMANN. The thing I am concerned about is this turning into some sort of discovery proceeding. In other words, he makes his proffer and actually produces the people and the assistant U.S. attorney has to turn around to the narcotic agents and say (*a*) how much do we know about this fellow's activities; and (*b*) how much can we prove through the agent who is there; or (*c*) are we going to have to use undercover sources and that sort of thing.

Mr. SHATTUCK. Why would this compromise him? Why does the evidence have to be presented? I don't understand this. This is a discretionary act on the part of the court.

Mr. ACHESON. That is right, Mr. Shattuck. But——

Mr. SHATTUCK. There is no reference to a hearing in open court as an adversary proceeding, such as Mr. Hoffmann's questions would lead you to believe.

Mr. ACHESON. Well, that is the question, it seems to me, and I am not so sure that you could avoid a hearing, because let's take the analogy of a mental examination on competency.

Mr. SHATTUCK. On that point, sir, on a mental examination, prior to a criminal proceeding, it is a very direct—has a very direct connection with the criminal proceeding. The man's mental competency is a very important factor as to whether he will be tried for the offense and so on. Whereas this, where the man is eligible for civil commitment, it will not be a factor in the criminal proceeding in any way.

Mr. ACHESON. Well, it is a question you have to decide before you can begin a criminal proceeding; that is, before you can take him to trial. If he is eligible, and if the judge should determine all of these questions in his favor, then he can make an election and the court can order him to treatment and the court has to decide whether the report and other information coming to his attention should lead him down that fork or the other fork.

Mr. SHATTUCK. That is right, sir. But you said also that the court has to tell him why, the reason, and the answer to the question of why is that I find you are not eligible for civil commitment, and must stand trial on the criminal charge, and this is all of the answer that I see need be given under this bill.

Mr. ACHESON. Well, assuming you are right, Mr. Shattuck, a court nevertheless might want to determine the underlying factual issues in the hearing, to support that decision. And I think Mr. Hoffmann's point only goes to this, that if a court wants to consider, to support its discretion, evidence that the addict was or was not selling to support his own habit, how do you meet the questions of proof? And it is a difficult question.

Mr. SHATTUCK. Yes. We appreciate anything you can give us on it. I am raising these questions to try to develop this.

Mr. SENNER. Mr. Giordano, in response to Congressman Gilbert's question to you about the addicts out of the 1,500 you arrest, I think you gave a figure of 450 to 500, how many of these addicts are arrested for selling narcotics, as defined by the act, who are addicts? In other words, out of the 450 what figure do we have, in talking about this instance of selling to support the habit?

Mr. GIORDANO. Well, I would say that the majority of our cases are made against the important traffickers and they are sale cases, by and large. We do have some that involve only possession, but the majority of the cases are sale cases. And the majority of the cases are cases that I question whether they would be able to make a showing of sale only to support their own habit.

Mr. SENNER. Then this probably would be the police records, your records, et cetera——

Mr. GIORDANO. The volume they have been selling, quantities. We are not involved—this is primarily at the State and local level, where they have the small pusher, who does get small quantities. But ours are usually in large quantities. You do have, in addition to these cases, the other cases that would I think, that the Federal Government makes, where this would apply more, which would be customs cases, across the border, particularly down in Mexico, where an addict goes across the border and comes back with what he says is just enough to support his own habit. That individual would come under the act.

Mr. SENNER. Jumping to a new question, I was talking with some members of the subcommittee about the question of whether or not to include marihuana within the purview of this bill, whether it should be inserted therein, on the basis that they have a psychological, mental problem. What is your thinking on that?

Mr. GIORDANO. Marihuana, first of all, is nonaddicting, and it is very difficult to determine whether or not a person is a marihuana user or is not a marihuana user. I think if you attempted to put marihuana in the bill you would open the gates for everybody making the claim of

being a marihuana user and it would be most difficult for anybody to determine whether he was or was not.

Mr. SENNER. Usually isn't marihuana the first step into the heroin field, and if we are trying to combat narcotics in this country, if we are going to take a step, let's take a full step, that is my thinking.

Mr. GIORDANO. It is a first stepping stone to heroin, but again I say it is almost impossible to make a determination whether or not the person is a marihuana user. And certainly they wouldn't need any hospitalization to take them off of marihuana, because there is no withdrawal.

Mr. SENNER. I am not talking about the hospitalization for the withdrawal symtoms that a narcotic addict would have, but in providing facilities with psychologists, psychiatrists, et cetera, to rehabilitate this person too, so that after the completion of the sentence he is not back on the streets picking up marihuana and away we go, to give him the treatment in the first instance.

What ramifications do you think it would have if we put it in there? Would it be just the fact that a person would say I am a marihuana smoker?

Mr. GIORDANO. I think everybody would come in and say it. I would, if I were involved in a situation like that. That is the first thing I would claim, I want treatment, I am a marihuana smoker. I think it would be unworkable.

Mr. SENNER. Isn't it true that those crimes that are committed by the person who is under the influence of marihuana, isn't his crime usually a crime of violence that would exclude him under the other portions of this bill?

Mr. GIORDANO. Well, they are involved in crimes of violence, but it wouldn't necessarily exclude him if he was caught just in possession of marihuana, and there were no showing of any other crime.

Mr. SENNER. That is true. But I mean one that was under the influence, rather than one that was in the possession of. Then you would know—well, is there any chemical way of testing a person to see whether or not he is under the influence of marihuana?

Mr. GIORDANO. There is none at the present time. There is research in this area, but at the present time there is no method of determining whether or not a person is a user or is under the influence. Sometimes doctors can determine from the action of the individaul and the fact that there is a half a marihuana cigarette in his possession at the same time, that he must have been using marihuana.

Mr. SENNER. But they can't tell by smelling or urinalysis or anything, analysis of the blood?

Mr. GIORDANO. No.

Mr. SENNER. Thank you.

Mr. GILBERT. Any other questions?

Mr. HOFFMANN. I have one or two related to this general subject.

You mentioned, Mr. Giordano, earlier, that the shortage of heroin that is occurring. Has the incidence of arrests of offenders with mixed habits—the use, and/or addiction or at least abuse of dangerous drugs—has the mixed habit increased with the disappearance of heroin?

Mr. GIORDANO. Yes, it has. In any areas of the country. Of course, we have a situation with the other drugs, which are the dangerous drugs, amphetamines and barbiturates, where this is more

widely spread than narcotics usage and not only in the larger cities, but it is in the smaller areas, which, of course, is not the situation with narcotic drugs today.

We did have in the 1930's a period of time when the use of narcotics was widespread all through the country. And now it is concentrated in major metropolitan areas. But the usage of amphetamines and barbiturates is increasing, not only in metropolitan areas, but other areas. Addicts are switching back and forth, which they didn't do before, and when they can't get heroin, they use barbiturates.

Mr. HOFFMANN. Looking toward the future then, assuming continued success with the enforcement against the so-called mainline drugs, do you see that what is now a narcotics problem is becoming more and more involved with dangerous drug problems?

Mr. GIORDANO. This is——

Mr. HOFFMANN. In other words, isn't the day coming when we will no longer be able to separate the two?

Mr. GIORDANO. This is becoming more difficult for our enforcement, in that we reduce the availability of a drug, and at times when this happens you have the possibility of some addicts staying off, but now with these other drugs it is sort of a crutch to carry them until the supply of heroin picks up.

Mr. HOFFMANN. Are these drugs and other substances being handled through the same distribution channels, by and large, that narcotics presently are?

Mr. GIORDANO. Not generally, no. But there has been in, I would say in the past year, an indication that some of the individuals who were handling heroin, are moving into this. People that have been handling marihuana are generally in this area of dangerous drugs.

I noted where former Commissioner Larrick indicated that he felt that organized crime was involved. I have not as yet found where the top hoodlums that we are dealing with in narcotics are involved in amphetamines and barbiturates. However, there is some indication that those who are handling these drugs are becoming organized, but they haven't been the top echelon of the criminal syndicates. But this dosen't say that they won't move into it.

Mr. HOFFMANN. Would you say, though, that the more widespread the use of these drugs, the larger, if you will, the fertile seedbed upon which drugs can fall, if our present enforcement breaks down? We have had several witnesses who have made fairly strong statements to the effect that Federal laws have been unnecessarily harsh, and the Federal approach to narcotics has been overly harsh, and some have even suggested that the penalties of the Boggs Act of 1951, and the Boggs-Daniels Act of 1956 should be extensively modified at this time. Perhaps you could just make a composite comment on what you think the effect of these strict penalties has been in the past and will be in the future?

Mr. GIORDANO. I think, Mr. Hoffmann, we may have furnished some charts at the last hearing which indicated the effect of the penalties Now these penalties are not aimed at curing the addict and never were aimed at curing the addict. The penalties were aimed at the traffickers, and the results since the first Boggs Act and since the Narcotics Control Act of 1956 have been very beneficial in reducing the availability of the heroin, in driving some of these people out of the traffic in nar-

cotics, and in the long run in generally containing the addict population, and even to where it has reduced the number of new addicts that are being formed.

But again I say the penalty doesn't cure a person of addiction, and it never was intended to. The same people who are saying that you should reduce the penalties and take away the minimum mandatory penalties on narcotics are the same ones that are saying we need stronger penalties for the dangerous drugs, so it is good for that, but not good for narcotics.

Well, it has actually been shown to be beneficial for narcotic enforcement and certainly would be beneficial in the dangerous drug area. But again I point out this is directed to the trafficker, to the seller.

Mr. HOFFMANN. I have about two more questions.

Mr. GILBERT. We are getting close to the time, Mr. Hoffmann. I wonder if you could cut it short.

Mr. HOFFMANN. Then perhaps we can put a statement of Mr. Giordano in the record that came up the other day.

I have one other question, and this is the last one. With regard to the initial fact you started out with, Mr. Giordano, this one-eighth ounce of heroin, which is the New York statutory dividing line, could you give us some idea for the record what the utility in the drug market of one-eighth of an ounce of heroin is, how much is it worth, how far will it go?

Mr. GIORDANO. Well, one-eighth of an ounce is about 60 grains and it varies, depending on where you are, what city you are in. But an addict will use anywhere from 3 to 10 or 15 grains a day. So the purpose of that one-eighth ounce, when it was introduced, was to assume that under one-eighth ounce, if a person had that in his possession, it was only for their own use, and if it was over an eighth of an ounce, it was for sale.

Well, the traffickers immediately learned of this, so they made a point of carrying as much as possible but less than one-eighth of an ounce, if they could.

It is very difficult to put a quantitative basis in a law—I can see some of our major traffickers getting out from under a sentence, because of the fact it was under one-eighth of an ounce, where you go into this house where they have scales, cellophane bags, and other paraphernalia, and all that is lift is a grain of heroin on the scale. Well, here you have a big trafficker, but if you use the one-eighth of an ounce division, you can just charge him with a misdemeanor.

This we have discussed with the New York State authorities, and have recommended that they eliminate this division, and even more so now that it is more or less frustrating the Metcalf-Volker Act.

Mr. GILBERT. Mr. Shattuck has one or two questions.

Mr. SHATTUCK. Yes, Mr. Acheson or Mr. Giordano.

Members have expressed a concern and they would like to have you gentlemen comment on the fact that this bill does better upon enforcement and in particular they want to be reassured that it would not in any way interfere with your efforts to enforce the law and in fact control the traffic. Do you have any comments on this?

In this connection I would like you to comment on title III concerning the sentencing and conviction and violation of law of young

adults, the youth offender extension, and the provisions concerning marihuana.

Mr. GIORDANO. As you know, the President's Commission felt that there should be some modification in the marihuana penalties. The Administration is drafting the bill and the Bureau of Narcotics' position was that we certainly didn't want to eliminate the minimum mandatory penalties, and there was also a feeling that the person involved in marihuana, which was the first approach to drugs, in many cases, would be a better individual for rehabilitation. And therefore the bill recommends parole for these people, or that they be offered parole, or have the opportunity.

Mr. SHATTUCK. This merely grants them the opportunities for parole.

Mr. GIORDANO. Right. And we certainly hope this will be used very judiciously. And I think this is the intent. And I think this is the same situation with the young adult.

In other words, they will have the opportunity, not that everybody is going to get that benefit.

Mr. ACHESON. I think it is worth while pointing out that the question of parole will be in the hands of the prosecuting arm of the Government, and will not be beyond any reach of the executive power as an open-ended sentencing power would be.

Mr. GILBERT. Since the beginning of these hearings in July of 1965, a number of additional bills on this subject have been introduced and referred to the Committee on the judiciary and in turn to this subcommittee. They will be inserted at this point in the record of the hearings.

(Material referred to follows:)

[H.R. 9886, 89th Cong., 1st sess.]

A BILL To amend title 18 of the United States Code with respect to criminal procedures and sentencing, and for other purposes

Be it enacted by the Senate and House of Representatives of the United State of America in Congress assembled,

CIVIL COMMITMENT

SECTION 1. (a) Part II of Title 18 of the United States Code is hereby amended by adding the end thereof the following new chapter:

"CHAPTER 239—CIVIL COMMITMENT

"Sec.
"3811. Election of civil commitment.
"3812. Disposition of election claim.
"3813. Period of civil commitment.
"3814. Termination of civil commitment.
"3815. Credit for commitment period.
"3816. Limitations on use of determinations made under civil commitment procedure.
"3817. Contracting with States for facilities.
"3818. Operative date.
"3819. Definitions.

"§ 3811. Election of civil commitment

"(a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is

determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this chapter.

"(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail or released on his own recognizance during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

"(c) The provisions of this Act shall not be applicable in the case of any person charged with knowingly selling narcotics to another for purposes of resale.

"§ 3812. Disposition of election claim

"(a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 3811, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this chapter as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

"(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

"(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

"(d) Whenever a drug user has been civilly committed pursuant to this chapter, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this chapter.

"§ 3813. Period of civil commitment

"(a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3812 of this chapter shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

"(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

"(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

"(3) the expiration of thirty-six months following the date on which such person is so committed.

"(b) With respect to any person returned to the court pursuant to the provisions of paragraphs (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program the Surgeon General may direct.

"(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

"§ 3814. Termination of civil commitment

"(a) If, while under any aftereare treatmeut program pursuant to section 3813, auy person—

"(1) fails or refuses to comply with any order of the Surgeon Geueral which (A) commands such persou to refrain from further use of any narcotic drug, and (B) was issued after such person had heen found by the Surgeon General, while under such program, to have heen using such drugs; or

"(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with sueh program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States Marshal to take such person iuto custody and may order the immediate resumption of the prosecution of criminal eharges against him.

"(b) Whenever the Surgeou General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of seetion 3813 of this chapter has successfully completed his probationary aftereare treatment program, the Surgeon General shall eertify that fact to the committing court and the court shall immediately dismiss the criminal charges against sueh person which were held in abeyance by reason of his commitment.

"§ 3815. Credit for commitment period

"In any case in which the prosecution of criminal charges against any person under this chapter is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the eustody of the United States Marshal and the Surgeon General pursuant to this chapter.

"§ 3816. Limitations on use of determinations made under civil commitment procedure

"Any determination hy a court under this chapter that a person is a nareotic addiet shall not he eonsidered a criminal eonviction, nor shall such person be considered a criminal hy reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a nareotie addict for purposes of this chapter, may be used in a further proceeding under this chapter, but may not be used against such person in connection with any eriminal charge held in abeyanee under this chapter, or in any other criminal proceediug.

"§ 3817. Contracting with States for facilities

"The Surgeon General is authorized to enter into contracts with the several States (including politieal subdivisions thereof) under which appropriate institutions and other facilities of such States or suhdivisions will be made avaliable, on a reimbursable hasis, for the eonfinement, eare, treatment, rehabilitation, and aftereare of persons civilly committed pursuant to this Act.

"§ 3818. Operative date

"The provisions of this Chapter shall not be applicable to auy ease pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

"§ 3819. Definitions

"As used in this chapter—

"(1) the term 'nareotic drug' or 'nareoties' shall include the substances defined as 'nareotic drugs', 'isonipecaine', and 'opiate' in section 4731 of the Internal Revenue Code of 1954, as amended;

"(2) the term 'narcotic addiet' means any person who habitually uses auy habit-forming nareotie drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addieted to the use of sueh habit-forming narcotie drugs as to have lost the power of self-control with reference to his addiction;

"(3) the term 'State' shall include the District of Columbia."

(b) The part analysis preceding chaper 1 of title 18, United States Code, is amended hy adding immediately after chapter 237 the following item:

"239. Civil commitment ..... 3811."

SENTENCING PROVISIONS

SEC. 2. (a) Chapter 402 of title 18 of the United States Code is amended by adding at the end thereof the following new section:

"§ 5027. Applicability of certain narcotic violators

"Subject to the provisions of subsection (d) of section 7237 of the Internal Revenue Code of 1954, as amended, the provisions of this chapter shall be applicable to all persons otherwise eligible, who are convicted of violations of any Federal penal law relating to narcotics notwithstanding the fact that a mandatory penalty is prescribed for any such violation."

(b) The analysis of chapter 402 of title 18, United States Code, is amended by adding at the end thereof the following:

"5027. Applicability to certain narcotic violators."

SEC. 3. Section 4209 of title 18, United States Code, is amended by adding at the end thereof the following new sentence: "Subject to the provisions of subsection (d) of section 7237 of the Internal Revenue Code of 1954, as amended, the provisions of this section shall be applicable to all persons otherwise eligible, who are convicted of violations of any Federal penal law relating to narcotics notwithstanding the fact that a mandatory penalty is prescribed for any such violations."

SEC. 4. Section 2(h) of the Narcotic Drugs Import and Export Act, as amended (21 U.S.C. 176a), is amended (1) by striking out "not less than five or" and inserting in lieu thereof "for not"; (2) by striking out "less than ten or"; and (3) by striking out "For provision relating to sentencing, probation, etc., see section 7237(d) of the Internal Revenue Code of 1954.".

SEC. 5. (a) Subsection (a) of section 7237 of the Internal Revenue Code of 1954, as amended, is amended (1) by striking out "not less than 2 or" and inserting in lieu thereof "for not"; (2) by striking out "not less than 5 or" and by inserting in lieu thereof "for not"; and (3) by striking out "not less than 10 or" and inserting in lieu thereof "for not".

(b) Subsection (b) of section 7237 of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(b) SALE OR OTHER TRANSFER WITHOUT WRITTEN ORDER.—

"(1) Whoever commits an offense, or conspires to commit an offense, described in section 4705(a) or section 4742(a) shall be imprisoned for not more than 20 years and, in addition, may be fined not more than $20,000. For a second or subsequent offense, the offender shall be imprisoned for not more than 40 years and, in addition, may be fined not more than $20,000.

"(2) If any offender under paragraph (1) attained the age of 18 before the offense and—

"(A) the offense consisted of the sale, barter, exchange, giving away, or transfer of any narcotic drug to a person who had not attained the age of 18 at the time of such offense, or

"(B) the offense consisted of a conspiracy to commit an offense described in paragraph (A),

the offender shall be imprisoned not less than 5 or more than 40 years and, in addition, may be fined not more than $20,000."

SEC. 6. (a) Subsection (d) of section 7237 of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(d) NO SUSPENSION OF SENTENCE; NO PROBATION.—Upon conviction of any offense the penalty for which is provided in subsection (b)(2) of this section or in subsection (c) or (i) of section 2 of the Narcotic Drugs Import and Export Act, as amended, the imposition or execution of sentence shall not be suspended and probation shall not be granted. Any person convicted of any such offense (including convictions in the District of Columbia) and sentenced to a definite term of years other than life shall be eligible for parole in accordance with the provisions of section 4202 of title 18 of the United States Code after such person has served for a period of not less than the mandatory minimum penalty prescribed by any such subsection for such offense. Any such person so convicted and sentenced to a term of life shall be eligible for parole in accordance with such section 4202 after such person has served for a period of at least 15 years of such life sentence."

TREATMENT OF FEDERAL PRISONERS

SEC. 7. (a) Chapter 301 of title 18 of the United States Code is amended by inserting immediately after section 4002, the following new section:

"§ 4002A. Use of State facilities for narcotics addicts

"(a) For the purpose of providing for the confinement, care, treatment, and rehabilitation (including vocational rehabilitation) of persons held under the authority of any enactment of Congress who are narcotic addicts, or who are suffering from a mental or physical condition which might be helped by proper care, treatment, or rehabilitation (including vocational rehabilitation), the Director of the Bureau of Prisons is hereby given authority, in addition to other authority available to him, to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States and subdivisions, specially equipped to provide such care, treatment, or rehabilitation, will be made available, on a reimbursable basis, for the aforementioned purposes.

"(b) As used in this section, and sections 4082A and 4082B of chapter 305 of this title, the term 'narcotic addict' means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such narcotic drugs as to have lost the power to self-control with reference to his addiction. As used in this subsection, the term 'narcotic drugs' shall include the substances defined as 'narcotic drugs', 'isonipecanine', and 'oplate' in section 4731 of the Internal Revenue Code of 1954, as amended."

(b) The analysis of chapter 301 of title 18, United States Code, is amended by inserting immediately after

"4002. Federal prisoners in State institutions; employment."

the following:

"4002A. Use of State facilities for narcotic addicts."

SEC. 8. (a) Chapter 305 of title 18 of the United States Code is amended by inserting immediately after section 4082, the following new sections:

"§ 4082A. Treatment authorized for certain persons committed to the custody of of the Attorney General

"(a) If the Attorney General determines that any person committed to his custody pursuant to section 4082 of this chapter is a narcotic addict, or is suffering from a mental or physical condition, and might be helped by proper care, treatment, or rehabilitation (including vocational rehabilitation), the Attorney General is hereby authorized, in addition to other authority available to him, to designate as the place of confinement for such persons, any appropriate institution or other facility of the United States, or any appropriate institution or other facility made available pursuant to section 4002A of this title, which is specially equipped to provide such care, treatment, or rehabilitation. The Attorney General may order any such person transferred from any one such institution or facility to any other such institution or facility.

"(b) Whenever the Attorney General determines that any person confined in an institution or facility pursuant to a designation by the Attorney General under subsection (a) of this section, or pursuant to an order of a United States court under section 4082B of this chapter, is no longer in need of such care, treatment, or rehabiliation, or that his continued confinement therein is no longer necessary or desirable, the Attorney General may transfer such person to any penal or correctional institution designated by the Attorney General to complete his original sentence. The time spent by such person in confinement in such institution or facility shall be considered as part of the term of his imprisonment.

"§ 4082B. Treatment authorized by the court for certain persons committed to the custody of the Attorney General

"In any case in which the court believes that a person convicted therein of violating a Federal penal law is a narcotic addict, or is suffering from a mental or physical condition, and might be helped by proper care, treatment, and rehabilitation (including vocational rehabilitation), the court may, after pronouncing sentence against such person, order the Attorney General to confine such person in an appropriate institution or facility in accordance with the provisions of section 4082A of this chapter."

(b) The analysis of chapter 305 of title 18, United States Code, is amended by inserting immediately after

"4082. Commitment to Attorney General; transfer."

the following:

"4082A. Treatment authorized for certain persons committed to the custody of the Attorney General.
"4082B. Treatment authorized by the court for certain persons committed to the custody of the Attorney General."

SEC. 9. (a) Chapter 311 of title 18 of the United States Code is amended by inserting immediately after section 4203, the following new section:

"§ 4203A. Use of certain public and private agencies for purposes of supervising certain parolees

"(a) In any case in which a person confined in any institution or other facility in accordance with the provisions of section 4082A or 4082B of this title is thereafter authorized by the Board of Parole to be released on parole under section 4203 of this chapter, the Board may, in its discretion, impose as a condition to such release a requirement that the person be placed, during the period of his parole, under the supervision of an appropriate State, public, or private agency, organization, or group, which, in the opinion of the Board, is (1) qualified to supervise such person during the period of his parole; and (2) specially equipped to provide such care, treatment, rehabilitation, or aftercare as he might require during such period. The Board shall receive and consider any recommendation of the Attorney General which in his opinion would be helpful to the Board with respect to the parole disposition of any case pursuant to this section.

"(b) For the purposes of subsection (a) of this section, the Board of Parole is authorized to utilize the services and facilities of any State, agency, organization, or group referred to in subsection (a) in accordance with a written agreement entered into between such State, agency, organization, or group and the Board of Parole. Payment for such services and facilities shall be made in such amount as may be provided in such agreement."

(b) The analysis of chapter 311 of title 18, United States Code, is amended by inserting immediately after

"4203. Application and release; terms and conditions."

the following:

"4023A. Use of certain public and private agencies for purposes of supervising certain parolees."

FACILITIES

SEC. 10. (a) For the purpose of financially assisting the several States in the construction of facilities for the treatment and rehabilitation of drug abusers, there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the two succeeding fiscal years, the sum of $15,000,000.

(b) Sums appropriated pursuant to subsection (a) shall be available for use by the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary") in (1) making grants under this Act to assist financially any State (which has submitted and had approved a State plan as hereinafter provided in this Act) in the construction of facilities for the treatment and rehabilitation of drug abusers; and (2) furnishing technical assistance to such State in designing, locating, and constructing such facilities.

(c) Sums appropriated pursuant to subsection (a) of this section shall remain available until expended for payments with respect to projects on which applications have been filed under section 13 of this Act before July 1, 1968, and approved by the Secretary before July 1, 1969. The full amount (as determined by the Secretary) of any grant for a project under this Act shall be reserved from any appropriations available therefor; and payments on account of such grant may be made only from the amount so reserved.

SEC. (a) Within six months after the enactment of this Act, the Secretary shall issue such regulations, applicable uniformly to all the States, as he may determine necessary to enable him to carry out the provisions of this Act. Such regulations shall include, among others, provisions prescribing—

(1) general standards of construction for any such facility the construction of which is financed at least in part from a grant under this Act; and

(2) the kinds of facilities and services needed to provide adequate treatment and rehabilitation for drug abusers.

(b) The regulations referred to in subsection (a) may include provisions requiring that (1) before approval of any application for a project pursuant to a State plan is recommended by any Agency, an assurance shall be received, by

the State filing such plan, from the applicant that a reasonable volume of treatment and rehabilitation services for drug abusers shall be made available to such drug abusers who are unable to pay for such services.

SEC. 12. (a) After the regulations referred to in section 11 have been issued, any State desiring to secure financial assistance under section 10 of this Act shall submit a State plan for carrying out the purposes of such section. Such plan must—

(1) set forth a program for construction of facilities for the treatment and rehabilitation of drug abusers which conforms with the regulations prescribed under section 11;

(2) designate a single State agency (referred to in this Act as the "Agency") as the sole agency for supervising the administration of the plan;

(3) contain satisfactory evidence that the Agency will have authority sufficient to carry out such plan in conformity with this Act;

(4) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(5) provide that the Agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

(6) provide for affording to every applicant for a grant for a project pursuant to a State plan an opportunity for hearing before the Agency;

(7) provide that the State will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) Any State desiring to submit a State plan as provided under subsection (a) shall submit such plan as a separate and distinct part of its State mental health plan submitted to the Public Health Service by the State's mental health authority in accordance with title III of the Public Health Service Act.

(c) The Secretary may approve any State plan (and any modification thereof) which is in substantial conformity with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

SEC. 13. (a) Any State or political subdivision thereof desiring to secure financial assistance under this Act for any project for the construction of facilities for the treatment and rehabilitation of drug abusers pursuant to an approved State plan shall submit, through the Agency, an application for a grant under this Act to assist it in carrying out such project. If any State and one or more political subdivisions thereof jointly participate in any such project, the application may be filed by one or more of the participants. The application shall set forth—

(1) a description of the site for such project;

(2) plans and specifications for such project in accordance with the regulations prescribed by the Secretary under subsection (a) of section 11 of this Act;

(3) reasonable assurances that title to such site is or will be vested in one or more of the applicants filing the application;

(4) reasonable assurances that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed;

(5) reasonable assurances that the applicant will meet the requirements if any, for furnishing treatment and rehabilitation services to drug abusers who are unable to pay for such services;

(6) such other information and assurances as the Secretary may, by regulation, require; and

(7) reasonable assurances that all laborers and mechanics employed by contractors or subcontractors in the performance of work on construction of the project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a–5); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth

in Reorganization Pian Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

(b) Tbe Secretary may approve any application fiied under this section if he finds tbat tbe application (1) is in substantial conformity with subsection (a) of this section and all applicable regulations issued pursuant to this Act; (2) is in substantiai conformity with tbe State pian approved under section 12 of this Act; and (3) has been approved and recommended by the Agency. No application fiied pursuant to this section shall be disapproved by tbe Secretary uutil he has afforded the applicant an opportunity for a hearing. Any amendment of an appiication approved under this Act shaii be subject to approval in the same manner as the original application.

SEC. 14. The payment of any grant to a State or poiitical subdivision under this Act may foliow tiie approval by the Secretary of the appiication of such State or subdivision. Any grant made pursuant to this Act for the construction of a projcct in any fiscal year shaii include such amounts as the Secretary determines to be nccessary in succeeding fiscal years for completion of tbc Federai participation in the project as approved by him. Payment of a grant may be madc in advance or by way of reimbursement, and in such instaiiments as may be determiued by the Secretary, and shaii be made on such conditions as tbe Secretary finds necessary to carry out the purposes of this Act. Amounts paid under this Act with respect to any projcct for the construction of a faciiity shali not exceed two-thirds of tbe constructiou costs of such faciiity as determined by the Secretary.

SEC. 15. Whenever tbe Secretary, after reasonabie notice and opportunity for hearing to the Agency finds—

(1) that the Agency is not complying substantially with the provisions required hy subsection (a) of sectiòn 12 to be included in its State pian, or with regulations under this Act;

(2) that any assurance required to be given in an appiication fiicd under subsection (a) of section 13 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out pians and specifications approved by the Secretary under section 13;

the Secretary may forthwith notify such Agency that no further payments will be made under this Act for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph 1, 2, or 3 of tbis subsection; and, except with regard to any project for which the appiication has already been approved and which is not directly affected, further payments in connection with such State pian may be withheid, in whoie or in part, untii there is no ionger any failure to comply (or to carry out the assurances or plans and specifications, as the case may be) or, if such compliance (or otber action) is impossibie, untii the State repays or arranges for the repayment of Federal moneys to wbich the recipient was not entitled.

SEC. 16. If any faciiity witb respect to which funds have been paid under tbis Act shaii, at any time within twenty years after compietion of its construction—

(1) be soid or transferred to any nonpublic organization; or

(2) ceasc to be used for tbc purposes for which it was constructed, uniess the Secretary determines, in accordance with regulations, tiiat there is good cause for reieasing the applicant from the obligation to continue such faciiity for the purpose of providing treatment for drug abusers;

tiie United States shaii be entitied to recover from tbc recipient of sucb funds an amount bearing the same ratio to the then vaiue (as determined by agreement of the parties or by action brought in tbe United States district court for the district in which the faciiity is situated) of the facility, as the amount of tbe Federai participation bore to the cost of coustruction of the faciiity.

SEC. 17. If any recipient of a grant under this Act is dissatisfied with any action taken by the Secretary under section 12(c), 15 or 16 of this Act, such recipient may appeal to the United States court of appeais for the circuit in which such recipient is iocated, by filling a petition with such court within sixty days after such action. A copy of the petition sbaii be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary therenpon shaii fiie in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the fiiing of such petition, tiie court shaii have jurisdiction to affirm the actiou of the Secretary or to set it aside, in whoie or in part, temporariiy or permanentiy, hut until the filing of tiic record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shaii be conclusivc, but tiie

court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

SEC. 18. (a) The Secretary is authorized to appoint such technical or other advisory committees as he deems necessary to advise him in connection with carrying out the provisions of this Act.

(b) Members of any such committees not otherwise in the employ of the United States, while attending meetings of their committee, shall be entitled to receive compensation at a rate to be fixed by the Secretary, but not exceeding $75 per diem, including travel time; and while away from their homes or regular places of business, they be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons in the government service employed intermittently.

PROGRAMS OF CARE, TREATMENT, AND REHABILITATION

SEC. 19. (a) For the purpose of financially assisting the several States in establishing, developing, and maintaining treatment and rehabilitation services for drug abusers, there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the two succeeding fiscal years, the sum of $7,500,000.

(b) Of the amount appropriated pursuant to subsection (a) for each such fiscal year (1) not less than 80 per centum thereof shall be available for use by the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary") in (A) making grants under this Act to assist any State (which has submitted and had approved a State plan as hereinafter provided), in defraying expenses and other costs incurred by it in establishing, developing, and maintaining treatment and rehabilitation services for drug abusers (including the training of personnel necessary to operate such services and the conducting of statistical and biometric programs necessary for carrying out epidemiologic and longitudinal studies of drug addiction and abuse); and (B) providing technical assistance to such State in carrying out such services; and (2) not more than 20 per centum thereof shall be available for use by the Secretary in (A) making grants under this Act to assist any nonprofit organization (which has submitted and had approved an application as hereinafter provided) in defraying expenses and other costs incurred by it in establishing, developing, and maintaining such treatment and rehabilitation services as are referred to in clause (1) of this subsection; and (B) providing technical assistance to such organization in carrying out such services.

(c) Any sums appropriated pursuant to subsection (a) of this section shall remain available until expended for payments with respect to projects on which applications have been filed under section 22 or 23 of this Act before July 1, 1968, and approved by the Secretary before July 1, 1969. The full amount (as determined by the Secretary) of any grant under this section shall be reserved from any appropriations available therefore; and payments on account of such grant may be made only from the amount so reserved.

SEC. 20. (a) Within six months after the enactment of this Act, the Secretary shall issue such regulations, applicable uniformly to all the States, as he may determine necessary to enable him to carry out the provisions of sections 19 to 28. Such regulations shall include, among others, provisions prescribing the kinds of treatment and rehabilitation services for drug abusers for which grants may be made under this Act such as, but not limited to, detoxification or other medical treatment, physical therapy, family counseling, psychotherapy, vocational training, help in finding employment, or probation-type supervision.

(b) The regulations referred to in subsection (a) may include provisions requiring that (1) before approval of any application for a project pursuant to a State plan is recommended by any Agency, an assurance shall be received, by the State filing such plan, from the applicant that a reasonable volume of treatment and rehabilitation services for drug abusers shall be made available to such

drug abusers who are unable to pay for such services; and (2) each application filed by a nonprofit organization for financial assistance under clause (2) of subsection (b) of section 19 of this Act contain an assurance that a reasonable volume of such services shall be made available to such drug abusers who are unable to pay for such services.

SEC. 21. (a) After the regulations referred to in section 20 have been issued, any State desiring to secure financial assistance under clause (1) of subsection (b) of section 19 of this Act shall submit a State plan for carrying out the purposes of such clause. Such State plan must—

(1) set forth a program for providing for treatment and rehabilitation services for drug abusers which conforms with the regulations prescribed under section 20;

(2) designate a single State agency (referred to in this Act as the "Agency") as the sole agency for supervising the administration of the plan;

(3) contain satisfactory evidence that the Agency will have authority sufficient to carry out such plan in conformity with this Act;

(4) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(5) provide that the Agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

(6) provide for affording to every applicant for a grant for a project pursuant to a State plan an opportunity for hearing before the Agency;

(7) provide that the State will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) Any State desiring to submit a State plan as provided under subsection (a) shall submit such plan as a separate and distinct part of its State mental health plan submitted to the Public Health Service by the State's mental health authority in accordance with title III of the Public Health Service Act.

(c) The Secretary may approve any State plan (and any modification thereof) which is in substantial conformity with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

SEC. 22. (a) Any State, political subdivision of a State, or nonprofit organization desiring to secure financial assistance for any project for the treatment and rehabilitation of drug abusers pursuant to an approved State plan shall submit, through the Agency, an application for a grant under this Act to assist it in carrying out such project. If any State, subdivision, or organization jointly participate in any such project, the application may be filed by one or more of the participants. The application shall set forth—

(1) the kinds of treatment and rehabilitation services which will be provided under the project with respect to which such application is filed;

(2) reasonable assurances that the applicant is legally qualified and is competent to provide such services;

(3) reasonable assurances that the applicant will meet the requirements, if any, for furnishing treatment and rehabilitation services to drug abusers who are unable to pay for such services; and

(4) such other information and assurances as the Secretary may, by regulation, require.

(b) The Secretary may approve any application filed under this section, if he finds that the application (1) is in substantial conformity with subsection (a) of this section and all applicable regulations issued pursuant to this Act, (2) is in substantial conformity with the State plan approved under section 21 of this Act, and (3) has been approved and recommended by the Agency. No application filed pursuant to this section shall be disapproved by the Secretary until he has afforded the applicant an opportunity for a hearing.

SEC. 23. (a) Any nonprofit organization desiring to secure financial assistance for any project for the treatment and rehabilitation of drug abusers as provided under clause (2) of subsection (b) of section 19 of this Act shall submit to the Secretary an application for a grant under such clause to assist it in carrying

out such project. If two or more such organizations jointly participate in such project, the application may be filed by one or more of the participants. The application shall set forth—

(1) the kinds of treatment and rehabilitation services which will be provided under the project with respect to which such application is filed;

(2) an assurance that the applicant is legally qualified and is competent to provide such services;

(3) reasonable assurances that the applicant will meet the requirements, if any, for furnishing treatment and rehabilitation services to drug abusers who are unable to pay for such services; and

(4) such other information and assurances as the Secretary may, by regulation, require.

(b) The Secretary may approve any application filed under this section, if he finds (1) that the application is in substantial conformity with the provisions of subsection (a) of this section and all applicable regulations issued pursuant to this Act; and (2) after consultation with the Agency, that the application is not inconsistent with the State plan. No application filed pursuant to this section shall be disapproved by the Secretary until he has afforded the applicant an opportunity for a hearing.

(c) The Secretary may, by regulation, provide for regular reports to him by any recipient of a grant under this section.

SEC. 24. The payment of any grant to a State, political subdivision of a State, or nonprofit organization under this Act may follow the approval by the Secretary of the application of such State, subdivision, or organization. Such payment may be made by the Secretary in advance or by way of reimbursement, and in such installments as he may determine, and shall be made on such conditions as he finds necessary to carry out the purposes of this Act. Amounts paid under this Act with respect to any project covered by an application made under section 22 shall not exceed two-thirds of the cost of such project as determined by the Secretary.

SEC. 25. (a) There is hereby created an Advisory Committee on Drug Abuse (hereinafter referred to as the "Committee"), which shall consist of nine members appointed by the Secretary. Such members shall be appointed from among individuals concerned with the medical and social aspects of drug abuse and who are eminent in fields relating to the treatment and rehabilitation of drug abusers (including the field of research), such as psychiatry, psychology, general medical practice, pharmacology, internal medicine, vocational training, correctional rehabilitation, and law enforcement. Each member of the Committee shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and (2) the terms of the members of the first Committee appointed shall expire, as designated by the Secretary at the time of appointment, as follows: three at the end of sixteen months after their appointment, three at the end of thirty-two months after their appointment, and three at the end of four years after their appointment.

(b) It shall be the duty of the Committee to—

(1) advise, consult with, and make recommendations to the Secretary on matters relating to the administration of this Act;

(2) assist States desiring financial assistance under this Act in the preparation and filing of their State plans; and

(3) assist the Secretary in his carrying out of the purposes of section 301 of the Public Health Service Act with respect to narcotics by encouraging States, local agencies, laboratories, public and nonprofit agencies, and other qualified individuals to engage in research projects and collaborative studies, on a long-term-contract basis, into all aspects of drug abuse with a view to obtaining information, facts, and other data necessary to enable the various governmental entities and private agencies to meet and combat the many problems resulting from drug abuse.

(c) Members of the Committee, not otherwise in the employ of the United States, while attending meetings of the Committee or while otherwise serving at the request of the Secretary, shall be entitled to receive compensation at a rate to be fixed by the Secretary, but not exceeding $75 per diem, including travel time; and while away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons in the government service employed intermittently.

(d) The Committee shall elect a Chairman from among its members, and shall be provided, by the Secretary, with such technical, consultative, clerical, and other assistance as he determines necessary to enable it to carry out its duties under this section.

SEC. 26. (a) Whenever the Secretary, after reasonable notice and opportunity for hearing to the Agency, finds—

(1) that the Agency is not complying substantially with the provisions required by subsection (a) of section 21 to be included in its State plan, or with regulations under this Act;

(2) that any assurance required to be given in an application filed under subsection (a) of section 22 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out the treatment and rehabilitation services approved by the Secretary under section 22;

the Secretary may forthwith notify such Agency that no further payments will be made under this Act for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph 1, 2, or 3 of this subsection; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments in connection with such State plan may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurances or services, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

(b) Whenever the Secretary, after reasonable notice and opportunity for hearing to any nonprofit organization, which is the recipient of a grant under clause (2) of subsection (b) of section 19 of this Act, finds—

(1) that such recipient is not complying substantially with the provisions required by section 23 of this Act to be included in its application for such grant, or with regulations under this Act;

(2) that any assurance required to be given in such application filed under section 23 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out the treatment and rehabilitation services approved by the Secretary under section 23;

the Secretary may forthwith notify the recipient that no further payments will be made under this Act for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), or (3) of this subsection; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments under this Act to such recipient may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurances or services, as the case may be) or, if such compliance (or other action) is impossible, until the recipient repays the moneys to which it was not entitled.

SEC. 27. (a) In providing technical assistance pursuant to this Act, the Secretary is authorized to make studies with respect to matters relating to the treatment and rehabilitation of drug abusers, including the effectiveness of projects financed in whole or in part by grants made pursuant to this Act, to cooperate with and render technical assistance to States, political subdivisions of States, and nonprofit organizations with respect to such matters, and to provide short-term training and instruction in technical matters relating to the treatment and rehabilitation of drug abusers.

(b) The Secretary is authorized to collect, evaluate, publish, and disseminate information and materials relating to studies conducted pursuant to this Act, and to such other matters involving the treatment and rehabilitation of drug abusers as the Secretary may determine feasible. The Secretary may, to the extent he determines appropriate, make such information and materials available to the general public or to any agency, or other organization concerned with, or engaged in, the treatment and rehabilitation of drug abusers.

SEC. 28. In any case in which a State is dissatisfied with the actions of the Secretary under section 21(c), 22(b), or 26(a), or in which a nonprofit organization is dissatisfied with his actions under section 23(b) or 26(b), such State or organization, as the case may be, may appeal to the United States court of appeals for the circuit in which such State or organization is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action,

as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

SEC. 29. Section 341 of the Public Health Service Act (58 Stat. 682) is amended (1) by inserting immediately after "discipline of persons" the following: "who are physically or psychologically"; and (2) by inserting at the end of the first paragraph thereof the following new sentence: "Such hospitals shall, in addition to providing such care and treatment, engage in research, training, and demonstration in the techniques of treatment and social rehabilitation of addicts."

SEC. 30. Paragraph (j) of section 2 of the Public Health Service Act is amended by adding at the end thereof the following: "any drug which contains any quantity of (A) barbituric acid or any of the salts of barbituric acid, or (B) any derivative of barbituric acid which has been designated by the Secretary under section 502(d) of the Federal Food, Drug, and Cosmetic Act as habit forming; any drug which contains any quantity of (A) amphetamine or any of its optical isomers; (B) any salt of amphetamine or any salt of an optical isomer of amphetamine, or (C) any substance which the Secretary, after investigation, has found to be, and by regulation designated as, habit forming because of its stimulant effect on the central nervous system; any drug which contains any quantity of a substance which the Secretary, after investigation, finds, and by regulation designates as a substance which (A) affects or alters to a substantive extent, consciousness, the ability to think, critical judgment, motivation, mood, psychomotor coordination, or sensory perception, and (B) (i) is substantially involved in drug abuse ('drug abuse' being deemed to exist when drugs are used for their psychotoxic effects alone and not as therapeutic media prescribed in the course of medical treatment or when they are obtained through illicit channels), or (ii) has a substantial potential for such abuse by reason of the similarity of its effect to that of a drug already subject to this paragraph;".

SEC. 31. Paragraph (k) of section 2 of the Public Health Service Act is amended by adding at the end thereof the following: "or any person who repeatedly uses, on a periodic or continuous basis, for their psychotoxic effects alone and not as therapeutic media prescribed in the course of legitimate medical treatment, any drug or drugs capable of altering or affecting, to a substantive degree, the consciousness, mood, motivation, or critical judgment of an individual, or the psychomotor coordination or the perception of the auditory or visual sense of an individual;".

DEFINITIONS

SEC. 32. As used in this Act, the term—

(1) "State" shall include the District of Columbia;

(2) "drug abuser" means any person who repeatedly uses, on a periodic or continuous basis, for their psychotoxic effects alone and not as therapeutic media prescribed in the course of legitimate medical treatment, any drug or drugs capable of altering or affecting, to a substantive degree, the consciousness, mood, motivation, or critical judgment of an individual, or the psychomotor coordination or the perception of the auditory or visual sense of an individual. Such drugs shall include, without limitation thereto, the opiates, cocaine, marihuana, barbiturates, and amphetamines, but shall not include alcohol;

(3) "facilities" means buildings or other facilities which are operated for the primary purpose of assisting in the treatment and rehabilitation of drug abusers by providing, under competent professional supervision, detoxification or other medical treatment, physical therapy, family counseling, psychotherapy, vocational training, help in finding employment, or other

services. The term "facilities" shall include, among others, facilities for medical care, laboratories, community clinics, halfway houses, sheltered workshops, and camps;

(4) "construction" includes the creation of new buildings, acquisition, expansion, remodeling, and alteration of existing buildings, and payment of architect's fees. The term "construction" does not include the cost of off-site improvements and acquisitions of land.

[H.R. 10762, 89th Cong., 1st sess.]

A BILL To amend title 18 of the United States Code to enable the courts to deal more effectively with the problem of narcotic addiction, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That titles I and II of this Act may be cited as the "Narcotic Addict Rehabilitation Act of 1965".

SEC. 2. It is the policy of the Congress that certain individuals charged with, or convicted of, violating Federal laws should be afforded an opportunity for treatment if it is determined that they are narcotic addicts and such treatment is likely to result in their rehabilitation and return to society as useful members. It is the further policy of the Congress that alternative procedures should be afforded for use in sentencing certain individuals convicted of violating Federal laws relating to narcotic drugs or marihuana.

TITLE I—CIVIL COMMITMENT IN LIEU OF PROSECUTION

SEC. 101. (a) Part II of title 18 of the United States Code is hereby amended by adding at the end thereof the following new chapter:

"CHAPTER 239—CIVIL COMMITMENT

"Sec.
"3811. Election of civil commitment.
"3812. Disposition of election claim.
"3813. Period of civil commitment.
"3814. Termination of civil commitment.
"3815. Credit for commitment period.
"3816. Limitations on use of determinations made under civil commitment procedure.
"3817. Use of other facilities.
"3818. Operative date.
"3819. Definitions.

"§ 3811. Election of civil commitment

"(a) Subject to the provisions of subsection (c) of this section, any person suspected of being a narcotic addict who is charged with a violation of a Federal penal law shall, upon his appearance before a United States commissioner or district court of the United States, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the United States commissioner or district court of the United States, as the case may be, within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this chapter.

"(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Attorney General or the Surgeon General, as determined by the district court, for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this chapter be admitted to bail or released on his own recognizance during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed hereunder.

"(c) The provisions of this chapter shall not be applicable in the case of any person—

"(1) charged with a crime of violence;

"(2) charged with selling a narcotic drug, unless the court determines that such sale was for the primary purpose of enabling the individual to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug and such sale was made to another believed by such person to be a narcotic addict;

"(3) against whom there is pending a prior charge of a felony which has not been finally determined or who is on probation or whose sentence following conviction on such a charge, including any time on parole or mandatory release, has not been fully served; except that an individual on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment;

"(4) who has been convicted of a felony on two or more occasions;

"(5) who has been civilly committed under this chapter or any State proceeding because of narcotic addiction on two or more occasions.

"§ 3812. Disposition of election claim

"(a) Within ten days following the date on which any person is placed in the custody of the Attorney General or the Surgeon General, as the case may be, pursuant to subsection (b) of section 3811, the Attorney General or the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Attorney General or the Surgeon General shall return such person to the court for such further proceedings under this chapter as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney, if such person was placed in the custody of the Surgeon General. If the person with respect to whom such report was made wishes to contest the finding contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

"(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

"(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

"(d) Whenever a drug user has been civilly committed pursuant to this chapter, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this chapter.

"§ 3813. Period of civil commitment

"(a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3812 of this chapter shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the district court whenever either of the following events occurs:

"(1) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

"(2) the expiration of thirty-six months following the date on which such person is so committed.

"(b) With respect to any person returned to the court pursuant to the provisions of paragraph (1) or (2) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

"(c) While any person is under the custody of the Surgeon General, he shall report for such supervised aftercare treatment as the Surgeon General directs. He shall be subject to home visits and to such physical examination and reasonable regulation of his conduct as the supervisory aftercare authority establishes,

subject to the approval of the Surgeon General. The Surgeon General may, at any time, order such person to return for institutional treatment. The Surgeon General's order shall be a sufficient warrant for the supervisory aftercare authority, a United States marshal, a probation officer, or an agent of the Attorney General, to apprehend and return the individual to institutional custody as directed.

"§ 3814. Termination of civil commitment

"(a) If, while under treatment by the Surgeon General or any probationary aftercare treatment program pursuant to section 3813, any person—

"(1) is determined by the Surgeon General (A) to be not susceptible to treatment as a medical problem or (B) after twenty-four months of such treatment to be achieving no progress in such treatment;

"(2) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such probationary aftercare treatment program, to have been using such drugs; or

"(3) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such probationary aftercare treatment program;

the Surgeon General shall immediately notify the district court of that fact. Upon receiving such notification, the court may order the United States Marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

"(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 3813 of this chapter has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

"§ 3815. Credit for commitment period

"In any case in which the prosecution of criminal charges against any person under this chapter is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in institutional custody pursuant to this chapter.

"§ 3816. Limitations on use of determinations made under civil commitment procedure

"Any determination by a court under this chapter that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this chapter, may be used in a further proceeding under this chapter, but may not be used against such person in connection with any criminal charge held in abeyance under this chapter, or in any other criminal proceeding, except that the fact that he is a narcotic addict may be elicited on his cross-examination as bearing on his credibility as a witness.

"§ 3817. Use of other facilities

"(a) The Surgeon General may from time to time make such provision as he deems appropriate authorizing the performance of any of his functions under this title by any other officer or employee of the Public Health Service, or with the consent of the head of the department or agency concerned, by any Federal or other public or private agency or officer or employee thereof.

"(b) The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this chapter.

"§ 3818. Operative date

"The provisions of this chapter shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

"§ 3819. Definitions

"As used in this chapter—

"(1) The term 'narcotic drug' or 'narcotics' includes the substances defined as 'narcotic drugs', 'isonipecaine', and 'opiate' in section 4731 of the Internal Revenue Code of 1954, as amended.

"(2) The term 'narcotic addict' means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

"(3) The term 'State' includes the District of Columbia."

(b) The part analysis preceding chapter 1 of title 18, United States Code, is amended by adding immediately after chapter 237 the following item:

"239. Civil commitment ..... 3811."

TITLE II—SENTENCING TO COMMITMENT FOR TREATMENT

SEC. 201. (a) Title 18 of the United States Code is amended by adding after chapter 313 thereof the following new chapter:

"CHAPTER 314—COMMITMENT FOR TREATMENT OF NARCOTIC ADDICTS AND PERSONS WITH MENTAL OR PHYSICAL CONDITIONS

"Sec.
"4251. Definitions.
"4252. Commitment and treatment for eligible offenders.
"4253. Conditional release.
"4254. Supervision in the community.

"§ 4251. Definitions

"As used in this chapter—

"(1) The term 'addict' means any individual who habitually uses any narcotic drug as defined by section 4731 of the Internal Revenue Code of 1954, as amended, so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

"(2) The term 'crime of violence' includes voluntary manslaughter, murder, rape, mayhem, kidnaping, robbery, burglary, housebreaking, extortion accompanied by threats of violence, assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for more than one year, arson punishable as a felony, or an atempt to commit any of the foregoing offenses.

"(3) The term 'treatment' includes treatment in an institution and under supervised aftercare in the community and includes, but is not limited to, medical, education, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the eligible offender; in the case of an addict, by correcting his antisocial tendencies and ending his dependence on addicting drugs and his susceptibility to addiction.

"(4) The term 'felony' includes any offense in violation of a law of the United States, any State, any possession or territory of the United States, District of Columbia, the Canal Zone, or the Commonwealth of Puerto Rico, which at the time of the offense was punishable by death or imprisonment for a term exceeding one year.

"(5) The terms 'conviction' and 'convicted' mean the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere, and do not include a final judgment which has been expunged by pardon, reversed, set aside, or otherwise rendered nugatory.

"(6) The term 'eligible offender' means any individual who is convicted of an offense against the United States, but does not include—

"(A) an offender who is convicted of a crime of violence;

"(B) an offender who is convicted of selling a narcotic drug, unless the court determines that such sale was for the primary purpose of enabling the offender to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug and such sale was made to another believed by such person to be a narcotic addict;

"(C) an offender against whom there is pending a prior charge of a felony which has not been finally determined or who is on probation or whose sentence following conviction on such a charge, including any time on parole or mandatory release, has not been fully served; except that an offender on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment;

"(D) an offender who has been convicted of a felony on two or more prior occasions;

"(E) an offender who has been committed under chapter 239 of this title, or under any State proceeding because of narcotic addiction on two or more occasions.

"§ 4252. Commitment and treatment for eligible offenders

"(a) If the court determines that an eligible offender is an addict, or is suffering from a mental or physical condition, and might be rehabilitated or helped by treatment, the court may, after pronouncing sentence against such offender, commit such offender to the Attorney General for treatment. Such commitment shall be for an indeterminate period of time not to exceed ten years, but in no event shall it exceed the maximum sentence that could otherwise have been imposed.

"(b) Such commitment shall be in any institution or facility designated by the Attorney General. Any time spent by any offender in any institution or facility pursuant to such a commitment shall be considered as part of his term of imprisonment.

"(c) If the court determines that an eligible offender is not eligible for commitment for treatment under subsection (a), it shall impose such other sentence as may be authorized or required by law.

"§ 4253. Conditional release

"An offender committed under section 4252(a) may not be conditionally released until he has been treated for six months in an institution maintained or approved by the Attorney General for treatment. The Attorney General may then or at any time thereafter report to the Board of Parole whether the offender should be conditionally released under supervision. After receipt of the Attorney General's report, and certification from the Surgeon General of the Public Health Service that the offender has made sufficient progress to warrant his conditional release under supervision, the Board may in its discretion order such a release. In determining suitability for release, the Board may make any investigation it deems necessary. If the Board does not conditionally release the offender, or if a conditional release is revoked, the Board may thereafter grant a release on receipt of a further report from the Attorney General.

"§ 4254. Supervision in the community

An offender who has been conditionally released shall be under the jurisdiction of the Board as if on parole under the established rules of the Board and shall remain, while conditionally released, in the legal custody of the Attorney General. The Attorney General may contract with any appropriate public or private agency or any person for supervisory aftercare of a conditionally released offender. Upon receiving information that such an offender has violated his conditional release, the Board, or a member thereof, may issue and cause to be executed a warrant for his apprehension and return to custody. Upon return to custody, the offender shall be given an opportunity to appear before the Board, a member thereof, or an examiner designated by the Board, after which the Board may revoke the order of conditional release."

(b) The table of contents of "PART III.—PRISONS AND PRISONERS" of title 18, United States Code, is amended by inserting after

"313. Mental defectives ..... 4241"

a new chapter reference as follows:

"314. Narcotic addicts ..... 4251".

TITLE III—SENTENCING AFTER CONVICTION FOR VIOLATION OF LAW RELATING TO NARCOTIC DRUGS OR MARIHUANA

SEC. 301. Section 7 of the joint resolution of August 25, 1958 (72 Stat. 845), is amended to read as follows:

"SEC. 7. This Act does not apply to any offense for which a mandatory penalty provided; except that section 4209 of title 18, as amended, shall apply to any

offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended."

SEC. 302. Section 4209 of title 18, United States Code, is amended by (1) inserting immediately before the first sentence thereof "(a)" and (2) adding at the end thereof the following new subsections:

"(b) A defendant described in subsection (a) of this section who is convicted of a violation of any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended, shall, if the court is considering sentencing him to the custody of the Attorney General pursuant to the provisions of the Federal Youth Corrections Act, be committed to the custody of the Attorney General for observation and study in accordance with the provisions of section 5010(e) of this title. Before sentencing such a defendant to the custody of the Attorney General for treatment and supervision pursuant to the Federal Youth Corrections Act, the court must affirmatively find, in writing, that there is reasonable ground to believe that the defendant will benefit from the treatment provided thereunder.

"(c) Section 5010(a) of this title shall not be applicable to a defendant described in subsection (a) of this section who is convicted of a violation of any offense enumerated in section 7237(d) of the Internal Revenue Code of 1954, as amended."

SEC. 303. Section 7237(d) of the Internal Revenue Code of 1954, as amended, is amended to read as follows:

"(d) NO SUSPENSION OF SENTENCE; NO PROBATION; ETC.—Upon conviction—

"(1) of any offense the penalty for which is provided in subsection (b) of this section, subsection (c), (h), or (l) of section 2 of the Narcotic Drugs Import and Export Act, as amended, or such Act of July 11, 1941, as amended, or

"(2) of any offense the penalty for which is provided in subsection (a) of this section, if it is the offender's second or subsequent offense,

the imposition or execution of sentence shall not be suspended, probation shall not be granted, and in the case of a violation of a law relating to narcotic drugs, section 4202 of title 18, United States Code, and the Act of July 15, 1932 (47 Stat. 696; D.C. Code 24–201 and following), as amended, shall not apply."

SEC. 304. The Board of Parole is hereby directed to review the sentence of any prisoner who, before the enactment of this Act, was made ineligible for parole by section 7237(d) of the Internal Revenue Code of 1954, as amended, and (1) who was convicted of a violation of a law relating to marihuana or (2) who was convicted of a violation of a law relating to narcotic drugs and had not attained his twenty-sixth birthday prior to such conviction. After conducting such review the Board of Parole may authorize the release of such prisoner on parole pursuant to section 4202 of title 18, United States Code. If the Board of Parole finds that there are reasonable grounds to believe that such prisoner may benefit from the treatment provided under the Federal Youth Corrections Act (18 U.S.C., ch. 402), it may place such prisoner in the custody of the Youth Corrections Division of the Board of Parole for treatment and supervision pursuant to the provisions of the Federal Youth Corrections Act. Action taken by the Board of Parole under this section shall not cause any prisoner to serve a longer term than would be served under his original sentence.

TITLE IV—CONSTRUCTION OF FACILITIES FOR CARE AND TREATMENT OF DRUG ABUSERS

SEC. 401. As used in this title—

(1) The term "State" includes the District of Columbia.

(2) The term "Secretary" means the Secretary of Health, Education, and Welfare.

(3) The term "drug abuser" means any person who repeatedly uses, on a periodic or continuous basis, for their psychotoxic effects alone and not as therapeutic media prescribed in the course of legitimate medical treatment, any drug or drugs capable of altering or affecting, to a substantive degree, the consciousness, mood, motivation, or critical judgment of an individual, or the psychomotor coordination or the perception of the auditory or visual sense of an individual. Such drugs shall include, without limitation thereto, the opiates, cocaine, marihuana, barbiturates, and amphetamines, but shall not include alcohol.

(4) The term "facilities" means buildings or other facilities which are operated for the primary purpose of assisting in the treatment and rehabilitation of drug abusers by providing, under competent professional supervision, detoxi-

fication or other medical treatment, physical therapy, family counseling, psychotherapy, vocational training, help in finding employment, or other services. The term "facilities" shall include, among others, facilities for medical care, laboratories, community clinics, halfway houses, sheltered workshops, and camps.

(5) The term "construction" includes the creation of new buildings, acquisition, expansion, remodeling, and alteration of existing buildings, and payment of architect's fees. The term "construction" does not include the cost of off-site improvements and acquisitions of land.

SEC. 402. (a) For the purpose of financially assisting the several States in the construction of facilities for the treatment and rehabilitation of drug abusers, there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the two succeeding fiscal years, the sum of $15,000,000.

(b) Sums appropriated pursuant to subsection (a) shall be available for use by the Secretary in (1) making grants under this title to assist financially any State (which has submitted and had approved a State plan as hereinafter provided in this title) in the construction of facilities for the treatment and rehabilitation of drug abusers; and (2) furnishing technical assistance to such State in designing, locating and constructing such facilities.

(c) Sums appropriated pursuant to subsection (a) of this section shall remain available until expended for payments with respect to projects on which applications have been filed under section 406 of this Act before July 1, 1968, and approved by the Secretary before July 1, 1969. The full amount (as determined by the Secretary) of any grant for a project under this title shall be reserved from any appropriations available therefor; and payments on account of such grant may be made only from the amount so reserved.

SEC. 403. (a) For the purpose of financially assisting the several States in establishing, developing, and maintaining treatment and rehabilitation services for drug abusers, there is hereby authorized to be appropriated for the fiscal year beginning July 1, 1965, and for each of the two succeeding fiscal years, the sum of $7,500,000.

(b) Of the amount appropriated pursuant to subsection (a) for each such fiscal year (1) not less than 80 per centum thereof shall be available for use by the Secretary in (A) making grants under this title to assist any State (which has submitted and had approved a State plan as hereinafter provided), in defraying expenses and other costs incurred by it in establishing, developing, and maintaining treatment and rehabilitation services for drug abusers (including the training of personnel necessary to operate such services and the conducting of statistical and biometric programs necessary for carrying out epidemiologic and longitudinal studies of drug addiction and abuse); and (B) providing technical assistance to such State in carrying out such services; and (2) not more than 20 per centum thereof shall be available for use by the Secretary in (A) making grants under this title to assist any nonprofit organization (which has submitted and had approved an application as hereinafter provided) in defraying expenses and other costs incurred by it in establishing, developing, and maintaining such treatment and rehabilitation services and as referred to in clause (1) of this subsection; and (B) providing technical assistance to such organization in carrying out such services.

(c) Any sums appropriated pursuant to subsection (a) of this section shall remain available until expended for payments with respect to projects on which applications have been filed under section 406 of this title before July 1, 1968, and approved by the Secretary before July 1, 1969. The full amount (as determined by the Secretary) of any grant under this section shall be reserved from any appropriations available therefor; and payments on account of such grant may be made only from the amount so reserved.

SEC. 404. (a) (1) Within six months after the enactment of this title, the Secretary shall issue such regulations, applicable uniformly to all the States, as he may determine necessary to enable him to carry out the provisions of section 402 of this title. Such regulations shall include, among others, provisions prescribing—

(A) general standards of construction for any such facility the construction of which is financed at least in part from a grant under this title; and

(B) the kinds of facilities and services needed to provide adequate treatment and rehabilitation for drug abusers.

(2) The regulations referred to in paragraph (1) may include provisions requiring that before approval of any application for a project pursuant to a State plan is recommended by any agency, an assurance shall be received, by the State filing such plan, from the applicant that a reasonable volume of treat-

ment and rehabilitation services for drug abusers shall be made available to such drug abusers who are unable to pay for such services.

(b) (1) Within six months after the enactment of this title, the Secretary shall issue such regulations, applicable uniformly to all the States, as he may determine necessary to enable him to carry out the provisions of section 403. Such regulations shall include, among others, provisions prescribing the kinds of treatment and rehabilitation services for drug abusers for which grants may be made under this title such as, but not limited to, detoxification or other medical treatment, physical therapy, family counseling, psychotherapy, vocational training, help in finding employment, or probation-type supervision.

(2) The regulations referred to in paragraph (1) may include provisions requiring that (A) before approval of any application for a project pursuant to a State plan is recommended by any agency, an assurance shall be received, by the State filing such plan, from the applicant that a reasonable volume of treatment and rehabilitation services for drug abusers shall be made available to such drug abusers who are unable to pay for such services; and (B) each application filed by a nonprofit organization for financial assistance under clause (2) of subsection (b) of section 403 of this title contain an assurance that a reasonable volume of such services shall be made available to such drug abusers who are unable to pay for such services.

SEC. 405. (a) After the regulations referred to in section 404 have been issued, any State desiring to secure financial assistance under section 402 or under clause (1) of subsection (b) of section 403 of this title shall submit a State plan for carrying out the purposes of such section. Such plan must—

(1) set forth a program for (A) in the case of a plan for assistance under section 402, construction of facilities for the treatment and rehabilitation of drug abusers which conforms with the regulations prescribed under section 404(a); or (B) in the case of a plan for assistance under clause (1) of section 403, providing for treatment and rehabilitation services for drug abusers which conforms with the regulations prescribed under section 404(b);

(2) designate a single State agency (referred to hereafter in this title as the "agency") as the sole agency for supervising the administration of the plan;

(3) contain satisfactory evidence that the agency will have authority sufficient to carry out such plan in conformity with this title;

(4) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(5) provide that the agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

(6) provide for affording to every applicant for a grant for a project pursuant to a State plan an opportunity for hearing before the agency;

(7) provide that the State will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) Any State desiring to submit a State plan as provided under subsection (a) shall submit such plan as a separate and distinct part of its State mental health plan submitted to the Public Health Service by the State's mental health authority in accordance with title III of the Public Health Service Act.

(c) The Secretary may approve any State plan (and any modification thereof) which is in substantial conformity with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

SEC. 406. (a)(1) Any State or political subdivision thereof desiring to secure financial assistance under this title for any project for the construction of facilities for the treatment and rehabilitation of drug abusers pursuant to an approved State plan shall submit, through the agency, an application for a grant under this title to assist it in carrying out such project. If any State and one or more political subdivisions thereof jointly participate in any such project, the application may be filed by one or more of the participants. The application shall set forth—

(A) a description of the site for such project;

(B) plans and specifications for such project in accordance with the regulations prescribed by the Secretary under subsection (a) of section 404 of this Act;

(C) reasonable assurances that title to such site is or will be vested in one or more of the applicants filing the application;

(D) reasonable assurances that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed;

(E) reasonable assurances that the applicant will meet the requirements, if any, for furnishing treatment and rehabilitation services to drug abusers who are unable to pay for such services;

(F) such other information and assurances as the Secretary may, by regulation, require; and

(G) reasonable assurances that all laborers and mechanics employed by contractors or subcontractors in the performance of work on construction of the project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a–276a–5); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

(b) (1) Any State, political subdivision of a State, or nonprofit organization desiring to secure financial assistance for any project for the treatment and rehabilitation of drug abusers pursuant to an approved State plan shall submit, through the agency, an application for a grant under this Act to assist it in carrying out such project; and any nonprofit organization desiring to secure financial assistance for any project for the treatment and rehabilitation of drug abusers as provided under clause (2) of subsection (b) of section 403 of this Act shall submit to the Secretary an application for a grant under such clause to assist it in carrying out such project. If any State, subdivision, or organization jointly participate in any such project, the application may be filed by one or more of the participants. Each such application shall set forth—

(1) the kinds of treatment and rehabilitation services which will be provided under the project with respect to which such application is filed;

(2) reasonable assurances that the applicant is legally qualified and is competent to provide such services;

(3) reasonable assurances that the applicant will meet the requirements, if any, for furnishing treatment and rehabilitation services to drug abusers who are unable to pay for such services; and

(4) such other information and assurances as the Secretary may, by regulation, require.

(c) The Secretary may approve any application filed under this section if he finds that the application is in substantial conformity with subsection (a) or (b) of this section and all applicable regulations issued pursuant to this title; and (1) in the case of any application for assistance under clause (2) of subsection (b) of section 403, after consultation with the agency and a determination that it is not inconsistent with the State plan; or (2) in the case of any other application, after he finds that such application (A) is in substantial conformity with the State plan approved under section 405 of this title; and (B) has been approved and recommended by the agency. No application filed pursuant to this section shall be disapproved by the Secretary until he has afforded the applicant an opportunity for a hearing. Any amendment of an application approved under this Act shall be subject to approval in the same manner as the original application.

SEC. 407. (a) The payment of any grant to a State or political subdivision under section 402 of this title may follow the approval by the Secretary of the application of such State or subdivision. Any grant made pursuant to this title for the construction of a project in any fiscal year shall include such amounts as the Secretary determines to be necessary in succeeding fiscal years for completion of the Federal participation in the project as approved by him. Payment of a grant may be made in advance or by way of reimbursement, and in such installments as may be determined by the Secretary, and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of section 402 of this title. Amounts paid under this title with respects to any project for

the construction of a facility shall not exceed two-thirds of the construction costs of such facility as determined by the Secretary.

(b) The payment of any grant to a State, political subdivision of a State, or nonprofit organization under section 403(b) of this title may follow the approval by the Secretary of the application of such State, subdivision, or organization. Such payment may be made by the Secretary in advance or by way of reimbursement, and in such installments as he may determine, and shall be made on such conditions as he finds necessary to carry out the purposes of this Act. Amounts paid under this title with respect to any project covered by an application made under section 406(b) shall not exceed two-thirds of the cost of such project as determined by the Secretary.

SEC. 408. (a) Whenever the Secretary, after reasonable notice and opportunity for hearing to an agency, finds—

(1) that the agency is not complying substantially with the provisions required by subsection (a) of section 405 to be included in its State plan, or with regulations under this title;

(2) that any assurance required to be given in an application filed under subsection (a) of section 406 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 406(a) or the treatment and rehabilitation services approved by the Secretary under section 406(b);

the Secretary may forthwith notify such agency that no further payments will be made under this title for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), or (3) of this subsection; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments in connection with such State plan may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurances or plans and specifications, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

(b) Whenever the Secretary, after reasonable notice and opportunity for hearing to any nonprofit organization, which is the recipient of a grant under clause (2) of subsection (b) of section 403 of this title, finds—

(1) that such recipient is not complying substantially with the provisions required by section 406(b) of this title to be included in its application for such grant, or with regulations under this title;

(2) that any assurance required to be given in such application filed under section 406(b) is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out the treatment and rehabilitation services approved by the Secretary under section 406(c);

the Secretary may forthwith notify the recipient that no further payments will be made under this title for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), or (3) of this subsection; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments under this title to such recipient may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurances or services, as the case may be) or, if such compliance (or other action) is impossible, until the recipient repays the moneys to which it was not entitled.

SEC. 409. If any facility with respect to which funds have been paid under this title shall, at any time within twenty years after completion of its construction—

(1) be sold or transferred to any nonprofit organization; or

(2) cease to be used for the purposes for which it was constructed, unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant from the obligation to continue such facility for the purpose of providing treatment for drug abusers;

the United States shall be entitled to recover from the recipient of such funds an amount bearing the same ratio to the then value (as determined by agreement of the parties or by action brought in the United States district court for the district in which the facility is situated) of the facility, as the amount of the Federal participation bore to the cost of construction of the facility.

SEC. 410. If any person affected thereby is dissatisfied with any action taken by the Secretary under section 405(c), 408, or 409 of this title, such person may appeal to the United States court of appeals for the circuit in which such re-

cipient is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

SEC. 411. (a) The Secretary is authorized to appoint such technical or other advisory committees as he deems necessary to advise him in connection with carrying out the provisions of this title.

(b) Members of any such committees not otherwise in the employ of the United States, while attending meetings of their committee, shall be entitled to receive compensation at a rate to be fixed by the Secretary, but not exceeding $75 per diem, including travel time; and while away from their homes or regular places of business, they shall be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons in the government service employed intermittently.

TITLE V—MISCELLANEOUS PROVISIONS

SEC. 501. Section 341 of the Public Health Service Act, as amended (58 Stat. 698; 68 Stat. 80; 70 Stat. 622; 42 U.S.C. 257), is amended to read as follows:

"SEC. 341. (a) The Surgeon General is authorized to provide for the confinement, care, protection, treatment, and discipline of persons addicted to the use of habit-forming narcotic drugs who are civilly committed to treatment or convicted of offenses against the United States and sentenced to treatment under chaper 239 or 314 of title 18, United States Code, addicts who are committed to the custody of the Attorney General pursuant to the provision of the Federal Youth Corrections Act, addicts who voluntarily submit themselves for treatment, and addicts convicted of offenses against the United States and who are not sentenced to treatment under title 18, United States Code, including persons convicted by general courts-martial and consular courts. Such care and treatment shall be provided at hospitals of the service especially equipped for the accommodation of such patients or elsewhere where authorized under other provisions of law, and shall be designed to rehabilitate such persons, to restore them to health, and, where necessary, to train them to be self-supporting and self-reliant, but nothing in this section or in this part shall be construed to limit the authority of the Surgeon General under other provisions of law to provide for the conditional release of patients and aftercare under supervision.

"(b) Upon the admittance to, and departure from, a hospital of the service of a person who voluntarily submitted himself for treatment pursuant to the provisions of this section, and who at the time of his admittance to such hospital was a resident of the District of Columbia, the Surgeon General shall furnish to the Commissioners of the District of Columbia or their designated agent, the name, address, and such other pertinent information as may be useful in the rehabilitation to society of such person."

SEC. 502. (a) There is hereby created an Advisory Committee on Drug Abuse (hereinafter referred to as the "Committee"), which shall consist of nine members appointed by the Secretary. Such members shall be appointed from among individuals concerned with the medical and social aspects of drug abuse and who are eminent in fields relating to the treatment and rehabilitation of drug abusers (including the field of research), such as psychiatry, psychology, general medical practice, pharmacology, internal medicine, vocational training, cor-

rectional rehabilitation, and law enforcement. Each member of the Committee shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and (2) the terms of the members of the first Committee appointed shall expire, as designated by the Secretary at the time of appointment, as follows: three at the end of sixteen months after their appointment, three a the end of thirty-two months after their appointment, and three at the end of four years after their appointment.

(b) It shall be the duty of the Committee to—

(1) advise, consult with, and make recommendations to the Secretary on matters relating to the administration of this Act;

(2) assist States desiring financial assistance under this Act in the preparation and filing of their State plans; and

(3) assist the Secretary in his carrying out of the purposes of section 301 of the Public Health Service Act with respect to narcotics by encouraging States, local agencies, laboratories, public and nonprofit agencies, and other qualified individuals to engage in research projects and collaborative studies, on a long-term-contract basis, into all aspects of drug abuse with a view to obtaining information, facts, and other data necessary to enable the various governmental entities and private agencies to meet and combat the many problems resulting from drug abuse.

(c) Members of the Committee, not otherwise in the employ of the United States, while attending meetings of the Committee or while otherwise serving at the request of the Secretary, shall be entitled to receive compensation at a rate to be fixed by the Secretary, but not exceeding $75 per diem, including travel time; and while away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons in the Government service employed intermittently.

(d) The Committee shall elect a Chairman from among its members, and shall be provided, by the Secretary, with such technical, consultative, clerical, and other assistance as he determines necessary to enable it to carry out its duties under this section.

SEC. 503. The Surgeon General and the Attorney General are authorized to give representatives of States and local subdivisions thereof the benefit of their experience in the care, treatment, and rehabilitation of narcotic addicts so that each State may be encouraged to provide adequate facilities and personnel for the care and treatment of narcotic addicts in its jurisdiction.

SEC. 504. If any provision of this Act or the application thereof to any person or circumstance is held invalid, the remainder of the Act and the application of such provision to other persons not similarly situated or to other circumstances shall not be affected thereby.

SEC. 505. Title I of this Act shall take effect three months after the date of its enactment and shall apply to any case pending in a district court of the United States in which an appearance has not been made prior to such effective date. Titles II and III of this Act shall take effect on the date of its enactment and shall apply to any case pending in any court of the United States in which sentence has not yet been imposed as of the date of enactment.

SEC. 506. There are authorized to be appropriated such sums as are necessary to carry out the provisions of this Act.

[H.R. 11409, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committe thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(1) the violation involved the sale of narcotics by such person so charged to another, with knowledge that the person to whom the sale was made intended to dispose of such narcotics by resale;

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraph (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshall to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 12050, 89th Cong., 2d sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics shall, upon his appearance before a committing magistrate, be informed that (1)the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) shall be held in abeyance in the manner hereinafter provided, if he elects to submit to an examination to determine if he is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election within the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with the provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such a person is an narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the period beginning at the time of his election and ending at the time a determination is made by the court as to whether such person should be civilly committed thereunder.

(c) The provisions of this Act shall not be applicable in the case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(1) the violation involved the sale of narcotics by such person so charged to another, with knowledge that the person to whom the sale was made intended to dispose of such narcotics by resale;

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such charge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has been civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under this Act as may be necessary. A copy of the report shall be made available to the person examined and to the United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which

were previousiy heid in abeyance. If, however, the conrt determines that snch person is a narcotic addict, the conrt may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate Institntion or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facillty to any other snch institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shali be continued without finai disposition untii dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon Generai pursuant to subsection (c) of section 3 of this Act shali be committed for an indeterminate period of not to exceed thirty-six months. Any person to committed shall be released by the Surgeon Generai and returned to the committing court whenever any one of the foiiowing events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medicai prohiem because of his incorrigihility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon Generai that such person has heen effectively removed from the habituai nse of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which snch person is so committed.

(h) With respect to any person returned to the court pursuant to the provisions of paragraph (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the nse of narcotic drugs foiiowing his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon Generai may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of snbsection (a), the court may order an immediate resumption of the prosecution of the criminai charges against such person which were heid in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) faiis or refuses to compiy with any order of the Surgeon Generai whlch (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found hy the Surgeon Generai, whiie under such program, to have been using such drugs; or

(2) faiis or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon Generai shall immediateiy notify the committing court of that fact. Upon receiving snch notification, the court may order the United States marshal to take snch person into custody and may order the immediate resumption of the prosecution of the criminai charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon Generai's custody pursuant to subsection (b) of section 4 of this Act has successfuiiy compieted his prohationary aftercare treatment program, the Surgeon General shaii certify that fact to the committing court and the court shaii immedinely dismiss the criminai charges against such person which were heid in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminai charges against any person under this Act is resumed after having been heid in abeyance, such person shaii receive fuii credit, against any sentence which may he imposed, for the time spent by such person in the custody of the United States marshai and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shaii not he considered a criminai convlction, nor shaii such person be considered a criminal hy reason of such determination. The resuits of any hearing, examination, test, or proccdure, condncted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding under this Act, hut may not be used against such person in connection with any criminal charge held iu abeyance under this Act, or in any other criminai proceeding.

SEC. 8. The Surgeon Generai is authorized to enter into contracts with the several States (including political subdivisions thereof) under wiiich appropriate institutions and other faciiities of such States or subdivisions wiii be made available, on a reimbursable basis, for the confinement, care, treatment, rehabiiitation, and aftercare of persons civiliy committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 11409, 89th Cong., 1st sess.]

A BILL To authorize civil commitment in lieu of criminal punishment in certain cases involving narcotic addicts

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That as used in this Act—

(1) the term "narcotic drug" or "narcotics" shall include the substances defined as "narcotic drugs", "isonipecaine", and "opiate" in section 4731 of the Internal Revenue Code of 1954, as amended; and

(2) the term "narcotic addict" means any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction.

SEC. 2. (a) Subject to the provisions of subsection (c) of this section, any person charged with a violation of a Federal penal law relating to narcotics with shall, upon his appearance before a committing magistrate, be informed tbat (1) the prosecution of the criminal charges against such person (unless he is a person within the purview of subsection (c) of this section) sball be held in abeyance in the manner bereinafter provided, if he elects to submit to an examination to determine if be is a narcotic addict; (2) he shall have ten days following his appearance before the committing magistrate within which to make such an election; and (3) if he makes such an election witbin the prescribed ten days and it is determined on the basis of an examination that he is a narcotic addict, the court shall have jurisdiction to order him to submit to a mandatory civil commitment in accordance with tbe provisions of this Act.

(b) Any person who elects consideration for civil commitment in accordance with the provisions of subsection (a) of this section shall be placed under the custody of the Surgeon General for the purpose of an appropriate examination to determine whether such person is a narcotic addict. In no case shall any person who elects consideration for civil commitment under this Act be admitted to bail (or released on his own recognizance) during the peroid beginning at the time of his election and ending at the time a determination is made by the court as to wbether such person sbould be civilly committed thereunder.

(c) The provisions of this Act sball not be applicable in tbe case of any person charged with a violation of a Federal law relating to narcotics if it appears that—

(1) the violation involved the sale of narcotics by such person so charged to another, with knowledge tbat the person to whom the sale was made intended to dispose of such narcotics by resale;

(2) there is pending against the person in a court of the United States or of any State a prior charge of a felony and such cbarge has not been finally determined, or the person has been convicted of a felony and the sentence following such conviction, including any time on parole, has not been fully served;

(3) the person has been convicted in a court of the United States or of any State on a total of two or more prior occasions of a felony; or

(4) the person has ben civilly committed by the United States or any State on a total of two or more prior occasions because of his narcotics use.

SEC. 3. (a) Within ten days following the date on which any person is placed in the custody of the Surgeon General pursuant to subsection (b) of section 2, the Surgeon General shall cause such person to be examined for the purpose of determining whether he is a narcotic addict and shall transmit to the court a certified report of the results of the examination. Upon the transmission of such report, the Surgeon General shall return such person to the court for such further proceedings under tbis Act as may be necessary. A copy of the report shall be made available to the person examined and to tbe United States attorney. If the person with respect to whom such report was made wishes to contest the findings contained therein, the court shall promptly set the matter for hearing. The court shall cause a written notice of the time and place of such hearing to be served personally upon such person.

(b) In conducting such hearing, the court shall receive and consider all relevant evidence and testimony which may be offered, including the contents of the report referred to in subsection (a).

(c) If the court determines, on the basis of the report or, if a hearing is requested, on the basis of such hearing, that such person is not a narcotic addict, the court shall order such person to be held to answer the criminal charges which were previously held in abeyance. If, however, the court determines that such person is a narcotic addict, the court may order him committed to the custody of the Surgeon General for confinement, care, treatment, and rehabilitation in any appropriate institution or facility which is specially equipped to provide the aforementioned. The Surgeon General may transfer such person from any one such institution or facility to any other such institution or facility.

(d) Whenever a drug user has been civilly committed pursuant to this Act, the criminal charges which led to his arrest shall be continued without final disposition until dismissed in accordance with the provisions of this Act.

SEC. 4. (a) Any person committed to the custody of the Surgeon General pursuant to subsection (c) of section 3 of this Act shall be committed for an indeterminate period of not to exceed thirty-six months. Any person so committed shall be released by the Surgeon General and returned to the committing court whenever any one of the following events first occurs:

(1) a determination by the Surgeon General that such person cannot be treated as a medical problem because of his incorrigibility or nonresponsiveness to medical treatment;

(2) a determination by the Surgeon General that such person has been effectively removed from the habitual use of narcotic drugs; or

(3) the expiration of thirty-six months following the date on which such person is so committed.

(b) With respect to any person returned to the court pursuant to the provisions of paragraph (2) or (3) of subsection (a), the court, in order to insure that such person does not return to the use of narcotic drugs following his release from confinement, may again place such person under the custody of the Surgeon General for a period of not more than two years for such probationary aftercare treatment program as the Surgeon General may direct.

(c) Upon the return of any person to the committing court pursuant to paragraph (1) of subsection (a), the court may order an immediate resumption of the prosecution of the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 5. (a) If, while under any aftercare treatment program pursuant to section 4, any person—

(1) fails or refuses to comply with any order of the Surgeon General which (A) commands such person to refrain from further use of any narcotic drug, and (B) was issued after such person had been found by the Surgeon General, while under such program, to have been using such drugs; or

(2) fails or refuses to comply with any other order or directive of the Surgeon General issued in connection with such program;

the Surgeon General shall immediately notify the committing court of that fact. Upon receiving such notification, the court may order the United States marshal to take such person into custody and may order the immediate resumption of the prosecution of the criminal charges against him.

(b) Whenever the Surgeon General determines that any person placed under the Surgeon General's custody pursuant to subsection (b) of section 4 of this Act has successfully completed his probationary aftercare treatment program, the Surgeon General shall certify that fact to the committing court and the court shall immediately dismiss the criminal charges against such person which were held in abeyance by reason of his commitment.

SEC. 6. In any case in which the prosecution of criminal charges against any person under this Act is resumed after having been held in abeyance, such person shall receive full credit, against any sentence which may be imposed, for the time spent by such person in the custody of the United States marshal and the Surgeon General pursuant to this Act.

SEC. 7. Any determination by a court under this Act that a person is a narcotic addict shall not be considered a criminal conviction, nor shall such person be considered a criminal by reason of such determination. The results of any hearing, examination, test, or procedure, conducted to determine whether a person is a narcotic addict for purposes of this Act, may be used in a further proceeding

under this Act, but may not be used against such person in connection with any criminal charge held in abeyance under this Act, or in any other criminal proceeding.

SEC. 8. The Surgeon General is authorized to enter into contracts with the several States (including political subdivisions thereof) under which appropriate institutions and other facilities of such States or subdivisions will be made available, on a reimbursable basis, for the confinement, care, treatment, rehabilitation, and aftercare of persons civilly committed pursuant to this Act.

SEC. 9. As used in this Act, the term "State" shall include the District of Columbia.

SEC. 10. The provisions of this Act shall not be applicable to any case pending in any court of the United States arising out of an arrest made prior to December 31, 1965.

[H.R. 12050, 89th Cong., 2d sess.]

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Mr. GILBERT. I thank both of you gentlemen for appearing here this morning. You have both been very helpful to the committee.

Mr. SENNER. Mr. Chairman pro tem, I would like to request Mr. Giordano if he would have any objection if we inserted in the record at this point, and if you would have any objection, a speech that he deliverd to the International Narcotic Enforcement Officers Association at Miami Beach. I think this would be a good place to have it in the record. It is a very important speech, it calls Americans attention to the problems.

Mr. GILBERT. Certainly we will place it in the record.

(The speech referred to follows:)

Mr. Chairman, distinguished guests, members of the International Narcotic Enforcement Officers Association, on July 23, 1965, the President of the United States, Lyndon B. Johnson, announced the appointment of a 19-man National Crime Commission to guide this Nation in its war against the alarming increase in crime. Only a few days before he had appointed a Special Crime Commission for the District of Columbia and named as its chairman, Mr. Herbert J. Miller, Jr., who, until recently, had been the Assistant Attorney General of the United States. Many of you will probably remember his outstanding presentation at our meeting in San Francisco last year.

Both Commissions have already held preliminary meetings to map out their plans and areas of close study and it appears clear from the news stories that the whole subject of narcotic addiction, and drug abuse in general, will be one of the major targets of their probe in depth. For this reason, I believe that our conference here in this wonderful setting of Miami Beach, has taken on a special significance—for among us today are probably the most outstanding experts in narcotic law enforcement and related professions in the world. Nor can we forget the international conclave of law enforcement which follows. I refer, of course, to the annual conference of the International Associations of Chiefs of Police. The problem of narcotics and drug abuse and the illicit traffic in same will undoubtedly receive more attention than ever before in the discussions and presentations scheduled by that organization.

The situation then, as I see it, is unique. We have a problem and we recognize it—what is even more important, we have an aroused public opinion and firm determination on the part of the administration to find the solutions to that problem as one of the important facets of war on crime in general. It only remains then for each of us, as individuals and as representatives of hundreds of separate agencies, to insure that all the facts surrounding the problem are brought into the open—and no one person nor any one group, no matter how vocal or influential they seem to be, will be able to stampede this country into the blind acceptance of "magic panaceas" and unproven theories or alien philosophies. This is not the time for the headlining of premature claims for scientific breakthrough in the treatment of drug addicts. It is not the time for the abandonment of the admittedly difficult but progressively successful programs of narcotic law enforcement in exchange for the grossly misunderstood and potentially disastrous "give way" or "maintenance" programs which even some of our notable public figures

have fonnd appealing in the wild scramble for favor from the electorate—nor is it the time for narcotic law enforcement to puil itself into a protective shell of silence with the vain hope that somehow, ail the opposing forces will suddenly move on to more fruitful areas of assault, in the vain hope that we may be once again permitted to go about our business of reducing the availability of illegal drugs and putting the traffickers behind bars.

We have an obligation—a solemn obligation in my opinion, to see to it that ail the cards are laid out on the table in this crucial game. If we don't, we will only have ourselves to blame—because the men who have been selected by the President to come up with the answers will have to rely on the facts presented to them in making their final determination. I believe that we have the information they need—not all of it, certainly—but much of it. I believe, too, that the thousands of years of experience in narcotics represented at this gathering and in law enforcement in general, cannot and must not be permitted to go unheard during this most crucial period. We owe this much to onrselves and to society as a whole. At the same time, it is equally imperative that narcotic law enforcement present a united front lest we give the impression to society that our views are as many and varied as our members. Frankly, I am convinced that, where the fundamentals are at issue experienced narcotic law enforcement officers, no matter where their jurisdiction is located, would be in complete agreement.

I would ask, therefore, that we take another look at some of the false propaganda which so frequently turns up in the press and other news media, and on TV and radio—often in the very subtle form of dialog in dramatic presentations dealing with doctors, nurses, lawyers, etc. I am sure that you are all familiar with the programs I have in mind—where a "courageous and dedicated" defense counsel will argue his client's case on the basis of an emotional and impressive attack against the law itself—using with neat skill ail the usual falsehoods and completely unsupported statistics. You all know the stock statements—you have probably heard them many times before—phrases such as "society has made a criminal out of a poor sick person by making him turn to the underworld for his medicine"—"give away drugs and you will take away the profit motive"—"addicts are usually poor harmless people who never resort to violence—but harm only themselves."

And how does the courageous prosecutor answer the budding Clarence Darrows—generally, he makes a rather ineffective argument that the law is the law and must be upheld—that the evidence in the case against the addict speaks for itself—then the scene quickly switches to a private conference in the judge's chamber where the prosecutor and the judge agree privately with the defense counsel that really the law should be changed—it is a bad, ineffective law which has proven a failure—drug addiction is everywhere on the increase—and on and on—ad nauseum. Once in a while, the cast of characters changes to the young resident physician defying the law and the hospital board to maintain some blond beatnik who might otherwise have to take a bath and go to work. The dialog is the same—everyone is sick—from the addict up through the staff to the self-seeking financially conscious head of the medical staff—everyone; that is, except the courageous young genius just out of the medical school who feels that he can accomplish anything so long as his patient is comfortable and no one—no one, that is—dares to tell him what he can or cannot do—the law, his own profession, or anyone else. He alone is to judge what is or is not good for his beautiful young addict.

Gentlemen, in 1 week alone, no less than three such presentations appeared on the national networks and were probably viewed by anywhere from 20 to 40 million people across the Nation—from teenagers up to nursing home patients. And what is the ultimate effect of this nonsense—what is the end result of this constant hammering away by a few uninformed script writers? In my opinion, they have succeeded in convincing an alarming percentage of the public that everything is just the way they say it is—narcotic addicts are increasing like flies—that England, through its infinite wisdom, has managed to escape the ravages of addiction—and, in general, that we in law enforcement are at the root of most the Nation's problems relating to crime and addiction.

Somehow, someway, we in narcotics enforcement have to come up with the ways and means of overcoming the deluge of false and misleading propaganda reaching the public on this whole subject of narcotics. We have to find a solution, and quickly, before this false propaganda becomes so deeply rooted that it takes on the authenticity of Biblical quotations or the fundamentals of McGuffey's reader.

The project is challenging, I admit, but it is one which I believe this organization must give highest priority. We must tell the story just as dramatically, but factually—just as simply, but factually, and just as convincingly, yet factually—but where do we begin?

Might we not start off by giving society as a whole a true-to-life image of John Q. Addict? Let us, for example, never pass up an opportunity to tell the public that eight independent studies in the last 15 years by such diverse agencies as departments of health, probation offices, and college research groups have established beyond any doubt that 75 percent of the addicts in this country have had prior criminal records before their addiction and that those who conducted the studies, who have had access to juvenile records, have revealed preaddiction criminality approaching the 90-percent figure. So it is generally the criminal who turns to addiction rather than the addict who turns to crime. Any intelligent layman who becomes convinced of this fact—and it is as true as we are in Miami today—will see no solution to a crime problem by providing free drugs to criminal drug addicts. How can they be expected to live useful, productive lives on narcotics when their lives were enmeshed in crime before they became addicted?

Might we not also call a lie to the oftrepeated statement by armchair sociologists that it is the pushers who go about the country enticing youngsters to try narcotics in order to capture them as heroin customers for the rest of their lives? You, as experienced narcotic enforcement officers, laugh at this nonsense—but the general public eats it up—they really believe this to be true—especially when a committee on drug addiction of a highly respected medical group says it is so. God save us from the "experts" who are cropping up among us. Nevertheless, we must convince the public that it is not the pusher who spreads addiction—but it is the addict himself. Whatever the underlying physiological, sociological, or environmental factors that produce an addiction-prone personality, there is only one basic triggering cause for drug addiction, and that is the association of the addict with the nonaddict. We have recorded over 55,000 active narcotic addicts as of December 31, 1964—and when you examine their statements as to the cause of their addiction you will find the reason given as "association," "association, friends, curiosity." Thus it is the addict, as we in narcotic enforcement know, who breeds addicts. If the addict is diseased, as some would have you believe, then he has contracted a contagious disease and is more than willing to pass it on to his own circle of friends so that they too might share in the misery of his own degradation. Yet, as true as this fact of life is, we still find scores of influential persons and groups, from legislators to educators, from scientists to sociologists, who suggest—even urge—that the local, State, and Federal governments abandon the present programs of tight controls and strict enforcement—replacing them instead with free maintenance clinics or "filling stations"—or accomplishing the same end by the thinly disguised program of medical treatment where the term "treatment" is conveniently interpreted to mean the unending maintenance of addicts on narcotic drugs for the remainder of their lives. Gentlemen, I have long tried to avoid giving an impression that I am an alarmist. I am not one and I shall continue to avoid this pitfall—but when I read a newspaper account of a prominent candidate for high public office in New York City who tells the voters that he has searched his soul for a solution to the drug problem and is finally convinced that the only answer lies in giving away drugs, then I feel I have—and you have—good reason for concern.

When I read in a widely distributed weekly magazine the statements attributed to a prominent woman physician allegedly engaged in scientific research on drug addiction that "junkies are fascinating people"—"I like them," she says, "because they are not stereotyped"—I again feel I have good reason to be concerned, as do you.

The well-known columnist, Jenkins Lloyd Jones, recently took a long overdue swipe at this warped concept. He wrote that "the dignified term, 'subculture' is being heard more often to describe child deserters, muggers, and hopheads." Narcotic addicts are no longer unreliable bums who won't keep appointments with those trying to help them. Instead, as one clergyman attached to an east Harlem parish put it grandly, "they have appointments in their own culture that take precedence over appointments in the square culture."

Mr. Jones concludes his brief but effectively cutting commentary on our times and morals with the thought that "maybe the idea is that if we all get into the gutter no one will look down on anyone."

I venture to say that if everyone in this room today were to seize upon every opportunity to educate the public in the realities of drug addiction we could, in a very short time, repair much of the damage that has been done by these inexperienced and ofttimes irresponsible spokesmen for the philosophy of appeasement. When our local radio or TV station—or our PTA arranges a panel discussion on narcotics we should demand that the views of narcotic enforcement be heard—and, equally important, we should urge them to select a properly weighed diversity of opinion rather than the one-sided and obviously biased panel we so often encounter. There is no earthly reason either why we in enforcement should ever run scared when we find ourselves pitted against a member of the judiciary or some law school professor with opposing views, for no matter how articulate they may be or how clever their presentations, we have the advantage of an overwhelming abundance of facts—facts which can be presented in a quiet, methodical, and convincing manner. When a panelist extols the virtues of the so-called British system we can counter with the fact, as reported by the British Medical Association, that the number of nonmedical addicts in England increased 100 percent during the period from 1958 to 1962—that England's per capita consumption of narcotic drugs as reported to the United Nations is twice that of the United States—that their Parliament is alarmed to the extent that some Members are clamoring for tighter narcotic controls over the medical profession. We might also remind them of the recent and tragic death of Joshua MacMillan, grandson of the former Prime Minister, who died of an overdose of heroin at Oxford. We might even pass along the severe criticism of the English courts directed against a well-known lady doctor whose young addict patient died of an overdose, while the good doctor traveled about the world, shouting the wonders and miracles of her "maintenance therapy."

When the panelist turns his attack on the failures of law enforcement to arrest and convict the big shots in the narcotic racket we can counter with the fact that Vito Genovese and 200 top mafiosi have been jailed in the past 6 or 7 years for narcotic violations—that the heroin supply has been so drastically reduced that the average addict can no longer find sufficient drugs to meet his habit—that the addicts being treated at the various institutions across the country seldom display withdrawal symptoms more serious than a running nose—and we can put the frosting on the cake by informing them in no uncertain terms that for the last 5 months there has been an unprecedented shortage of heroin in the illicit market—with some heroin wholesalers offering from $25,000 to $35,000 per kilogram. This is what narcotic law enforcement has been able to accomplish—in spite of the many difficulties encountered along the way. We can suggest, rather effectively I submit, that it would be nothing less than absolute folly to replace the very limited and unreliable underworld supply of narcotic drugs with high-potency and virtually free drugs from the proposed "clinics" with the taxpayer footing the bill. What can we possibly gain by this immoral exchange? I, for one, find the suggestion nothing less than revolting—something which is unworthy of a great nation such as ours. To say that there is no other solution is appeasement, pure and simple. Let's make this a telling point in all our discussions.

Incidentally, while we are on the subject of legalizing drugs and the permissive approach in general, we might also take a look at the alarming increase in the use of marihuana and dangerous drugs at the colleges and universities across the Nation. Here again we find the same attitude prevailing among certain student groups, and even among some of the faculty for that matter, that there is really nothing wrong with the use of marihuana, LSD, or barbiturates. Yet we know that far too often the end result of this type of thinking is tragic.

Finally, gentlemen, I should like to dwell for a moment on the subject of medical research for an effective solution to narcotic drug addiction. This is an avenue which must be explored at great length and one which I believe offers great promise in the future. We in the Bureau of Narcotics have long advocated research programs as many of the Nation's top medical experts can attest—but at the same time, we have raised our voice in urging caution against the uncontrolled and improperly supervised programs—those directed by inexperienced and sometimes irresponsible men of medicine. Bona fide research is welcomed—but hastily conceived, poorly planned, and inadequately staffed research is something else. Most of the great scientists of history have elected to conduct their experiments in the quiet atmosphere of true scientific study—working day in and day out—carefully documenting their failures as well as their successes. Not until they have finally reached their long-sought goals, with their findings

adequately verified—have they felt justified in heralding their discoveries to the world. I predict that when science does make the breakthrough in search for a lasting cure for drug addiction, it will be made by men such as these who sought the answers, not personal aggrandizement.

But today, gentlemen, are we seeing the radical departure from this long-established precedence? Today, we find narcotic research programs being hailed across the Nation as unqualified successes—when in fact, they are still in the embryonic stage. We find the researchers themselves vying with one another for the spotlight of public acclaim and recognition—yet their projects have been underway scarcely more than a year. I would ask, what manner of medical research is this? More appropriately, one might ask—what are they seeking?—a solution or an excuse?—an excuse to carry out a program or a philosophy which they were convinced was right even before they examined their first addict.

These are the challenges we face—and this is where our responsibilities will lie. It only remains then for us to meet the challenges and accept the responsibilities. Let other groups or other countries seek the role of the appeasers—I am convinced they will someday learn that it is no more applicable to the war on narcotic addiction than it is in international politics.

Mr. GILBERT. I also ask that the statement of our colleague, Representative Charles Longstreet Weltner, of Georgia, be made a part of the record.

STATEMENT OF CHARLES LONGSTREET WELTNER, MEMBER OF CONGRESS

Mr. Chairman, I appreciate the opportunity to appear before this subcommittee in support of proposed legislation enabling the courts to deal more effectively with problems of narcotic addiction.

The Justice Department has recommended that specific steps be taken to rehabilitate rather than incarcerate the narcotic addict, and its recommendations are based on increased evidence throughout the Nation of the extent and tenacity of the problem.

I wanted particularly to speak to the need such legislation could fill in Atlanta. The Subcommittee on Crime and Health of the Atlanta Commission on Crime and Juvenile Delinquency completed a study in November on Crime and its ramifications in our city. One of its conclusions is that drug addiction, although not a major problem in Atlanta at the moment, is of increasing concern as the population of Atlanta grows.

Of particular concern is the illicit traffic of drugs and narcotics in and among Georgia's prison population. Although a many-pronged attack on the problem is required, the legislation under consideration here could be utilized to keep the narcotic addict out of prison and to make available as well as mandatory his treatment and rehabilitation.

The commission has also recommended the establishment of court clinics, and one projected function is to screen narcotic and drug offenders prior to trial and to make recommendations available to the judge before sentencing. If the present legislation is enacted, judges would have the option of civilly committing these offenders to the Surgeon General for treatment, based on the recommendations of the court clinic staff.

The traffic and use of narcotics have been slightly diminished by traditional corrective methods. I believe it is time to acknowledge by statute the unpleasant fact that drug addiction is a disease, and give our courts the opportunity to deal with narcotics on that basis.

The legislation has my full backing, and I hope that the committee will determine it to be in the best interests of the Nation to report it favorably.

Mr. GILBERT. Thank you gentlemen, again.

A communication of the Administrative Office of the U.S. Courts expressing the views of the Judicial Conference on the bill H.R. 9167 will be made a part of the record.

(The communication follows:)

ADMINISTRATIVE OFFICE OF THE U.S. COURTS,
Washington, D.C., January 18, 1966.

Hon. EMANUEL CELLER,
Chairman, Committee on the Judiciary,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN CELLER: In response to your request for the views of the Judicial Conference on H.R. 9167, a bill to amend title 18 of the United States Code to enable the courts to deal more effectively with the problem of narcotic addiction, and for other purposes, I can advise you that the Judicial Conference of the United States at its session on September 22–23, 1965, voted to approve this and identical legislation pending in the Senate; namely, S. 2152, with the following recommended amendment to title I.

An "eligible individual" is defined in title I as any person charged with an offense against the United States, except (1) a person charged with a crime of violence; (2) a person charged with selling narcotics, unless the court determines that the sale was incidental to the maintenance of his habit; (3) a person against whom there is pending a prior felony charge; (4) a probationer or parolee convicted of a felony charge; (5) a person convicted of a felony charge on two or more occasions; and (6) a person civilly committed on two or more occasions because of narcotic addiction.

Proposed title I provides that if the district court believes an "eligible individual" is an addict, it may advise him that the prosecution of the criminal charge will be held in abeyance if he elects to submit to an immediate examination to determine whether he is an addict and is likely to be rehabilitated through treatment. If he so elects, he is then civilly committed to the custody of the Surgeon General for such treatment, the period of commitment not to exceed 36 months (secs. 102(b) and 103(c)). During the treatment period prosecution on pending criminal charges will be held in abeyance. If the individual successfully completes his treatment program, and it is so certified by the Surgeon General, he would be discharged and the pending criminal charges would be dismissed (sec. 102(c)).

If the court determines that the individual "is not an addict or is an addict not likely to be rehabilitated through treatment," he would be held to answer the pending criminal charges.

It is the opinion of the Conference that an addict charged with an offense against the United States, other than one related to his addiction, should not be relieved of the obligation to answer the charge merely because he is an addict. The availability of such relief would place a premium on drug addiction and would result in an inequality in the administration of criminal justice. Such relief should be made available to an addict only where it is found by the court that the criminal charge against him is related to his addiction. Title I should be modified accordingly.

Sincerely,

WILLIAM E. FOLEY, *Deputy Director.*

The hearing is adjourned.

(Whereupon, at 12:05 a.m., the subcommittee was adjourned.)

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